

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wilbert Matthew Aaron		4. DATE OF DEATH Month Day Year October 26, 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1879
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman retired		9b. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman retired		10b. KIND OF BUSINESS OR INDUSTRY Fishing Creek	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Matthew Aaron		14. MOTHER'S MAIDEN NAME Sarah E. Hooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Gorman Phillips, Fishing Creek, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-27- 19 60 , to 10-26- 19 60 , that I last saw the deceased alive on 10-26- 19 60 , and that death occurred at 7:20 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert E. Barker M.D.		ADDRESS (Street, city or town, state) 200 Maryland Ave. Cambridge, Md.	
PHYSICIAN'S NAME (Type) Albert E. Barker		DATE SIGNED 10/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29, 1960	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel R. Shover		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR NOV 1 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kneave	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11358

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G274 11-14-60 et

CERTIFICATE OF DEATH

11314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Cecil b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Benjamin F. Anderson				4. DATE OF DEATH OCT 28 1960			
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870	9. AGE (In years lost birthday) ABOUT 90 yrs.	IF UNDER 1 YEAR: Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Jefferson Anderson				14. MOTHER'S MAIDEN NAME Margaret Ann Cantler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 14 1009		INFORMANT Address Hospital records Cambridge Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNK						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I attended the deceased from June 29, 1960 , to OCT 28, 1960 , that I last saw the deceased alive on OCT 27, 1960 , and that death occurred at 5:35 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED OCT 28 '60							
ACTUAL SIGNATURE Thomas J. Dredge M.D.							
PHYSICIAN'S NAME (Type) Thomas J. Dredge							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/60		22c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FUNERAL SERVICE MD				24a. REC'D BY REGISTRAR DATE NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only one within 72 hours after death.

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY
CHICAGO, ILLINOIS 60637
U.S.A.

TO THE EDITOR
OF THE JOURNAL OF THE
AMERICAN CHEMICAL SOCIETY

RE: [Illegible]

[Illegible text follows, appearing to be a letter or report. The text is too faint to transcribe accurately but seems to contain several paragraphs of discussion or data.]

Very truly yours,
[Illegible Signature]

[Illegible Address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11332

11315

Item 9 Filed 11-3-60 et

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>				c. LENGTH OF STAY IN 1b <u>1 Week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Myrtle E. Andrews</u>				4. DATE OF DEATH Month Day Year <u>10 7 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/11/1899</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Crapo, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William P. Andrews</u>				14. MOTHER'S MAIDEN NAME <u>Arianna Innsley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Emeett Andrews, Cambridge, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalitis, acute, Viral</u> 082-3 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>69 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> 19 <u>60</u> to <u>Oct 7</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Oct 7</u> 19 <u>60</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS <u>Cambridge, Md.</u>				22e. REC'D BY REGISTRAR			
22f. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>				22g. DATE <u>OCT 17 '60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/10/1960.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Church Yard.</u>		23d. LOCATION (City, town, or county) (State) <u>Crapo, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				25. REGISTRAR'S SIGNATURE			

2

1

067

1

1963

OFFICE OF THE ATTORNEY GENERAL

[Faint, mostly illegible text, possibly a letter or official document, with some visible words like "Dear Sir", "Very truly yours", and "Sincerely yours"]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12494

11333

1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle W. Last Andrews				4. DATE OF DEATH Month 10 Day 30 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/14/1904	
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 60		11. BIRTHPLACE (State or foreign country) Maryland, Dorchester, Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Waterman			
13. FATHER'S NAME Ellworth Andrews				14. MOTHER'S MAIDEN NAME Anna Willey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 10/23/42 2/6/43 212-16-5036			
17. INFORMANT Mrs. Richards Andrews, Lloyds, Maryland.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding gastro-jejunal ulcer few days 542.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 5 1960 to Oct 30 1960 that (I) (we) last saw the deceased alive on Oct 30 1960 , and that death occurred at 1 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Lewis M. Burdette				22b. DATE SIGNED 11/1/60			
22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette				22d. ADDRESS 1 Locust St, Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/2/1960.			
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery				23d. LOCATION (City, town, or county) (State) Baltimore, Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.				25a. REC'D BY REGISTRAR DATE NOV 9 '60			
				25b. REGISTRAR'S SIGNATURE Arthur P. K...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11334 11316

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN <u>MD</u> <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u> d. STREET ADDRESS <u>R.F.D. 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lena Christina Boevers</u>		4. DATE OF DEATH <u>Oct. 10 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/3/1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
13. FATHER'S NAME <u>Carsten Johannsen</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>August Boevers</u>	
17. INFORMANT <u>Christina ?</u>		Address <u>Vienna, Md. Rt. 1.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture neck femur.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 Hrs.</u> <u>2 weeks.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell while walking in yard.</u>	
20c. TIME OF INJURY Month, Day, Year <u>6</u> Hour <u>10/6/60</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Yard of home.</u>	20f. (City or town) (County) (State) <u>Vienna, Dor. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/21/60</u>	
		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial</u>
		22d. LOCATION (City, town, or country) (State) <u>Cambridge, Dor. Md.</u>	
23. FUNERAL DIRECTOR <u>Ruth Willoughby</u>		24a. REC'D BY REGISTRAR <u>OCT 31 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	

MEDICAL CERTIFICATION

1911

1911

1911

1911

1

1911

1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11335

11317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Harlock - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital			d. STREET ADDRESS 1 Near Zion		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Grover Middle Cleveland Last Corkran, Sr.			4. DATE OF DEATH Month October Day 28 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY Paper hanging		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Christopher C. Corkran			14. MOTHER'S MAIDEN NAME Eliza Andrew		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Elsie R. Corkran, Harlock, Maryland, R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture neck left femur, 8, 9, 10th ribs left. DUE TO (c) 2 days					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed.			
20c. TIME OF INJURY Hour 9 o. m. 10/26/60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Harlock	(County) Dor.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John Mace, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-31-60	
EXAMINER'S NAME (Type) John Mace, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 31, 1960	22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	22d. LOCATION (City, town, or county) (State) Near Williamsburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland			24a. REC'D BY REGISTRAR DATE NOV 7 '60		
			24b. REGISTRAR'S SIGNATURE Charles L. Hines		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

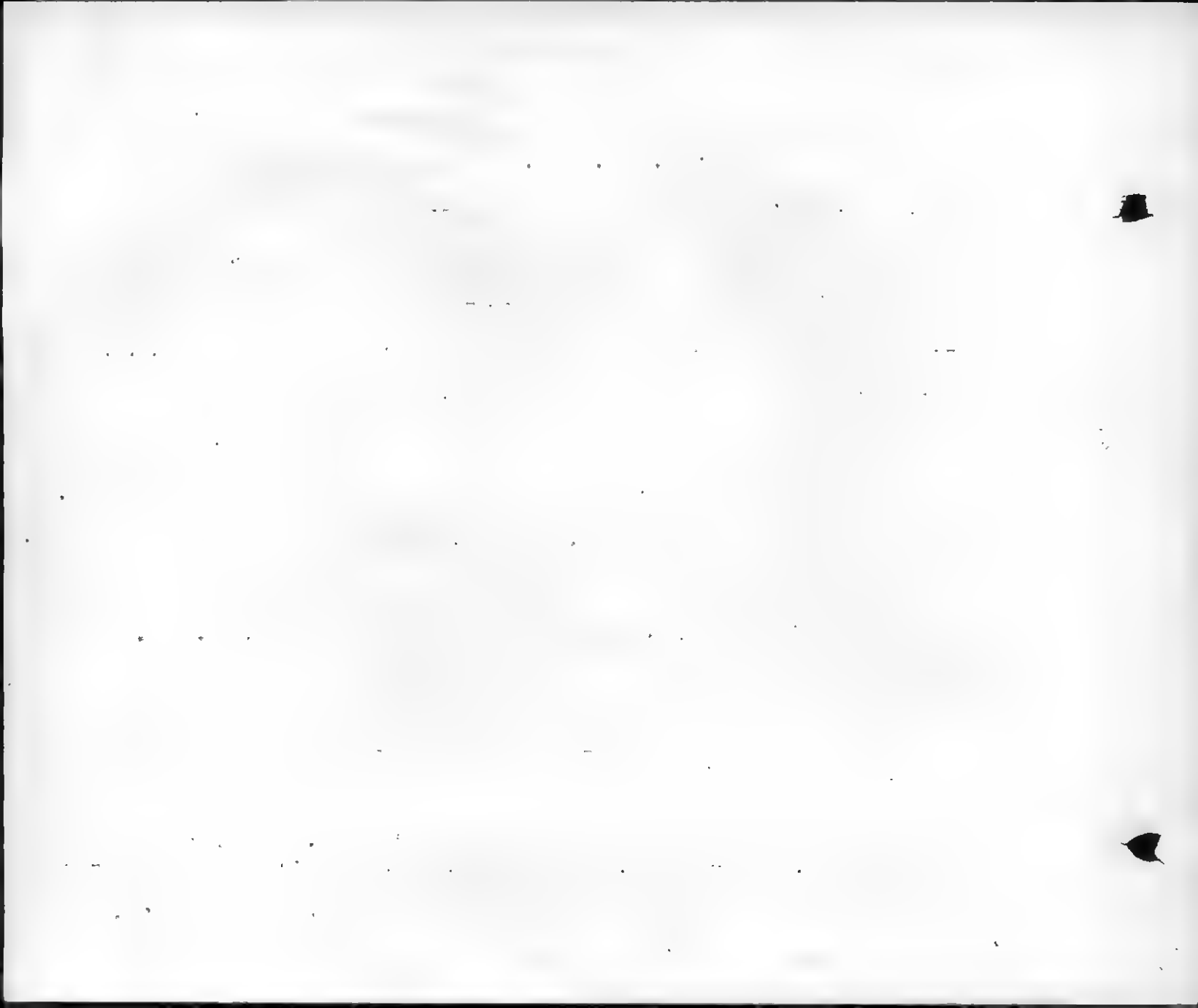


11359

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barksdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS --			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Fairo Last DeVinney				4. DATE OF DEATH Month October Day 22 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-05-81	
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George DeVinney				14. MOTHER'S MAIDEN NAME Georgianna Knotts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --				16. SOCIAL SECURITY NO. --			
17. INFORMANT Address Eastern Shore State Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) over 4 yrs.							INTERVAL BETWEEN ONSET AND DEATH 15 mins.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Senile Brain Disease W. Psy. Reac.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 4-24 , 19 57 , to 10-22 , 19 60 , that I last saw the deceased alive on 10-22 , 19 60 , and that death occurred at 12:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Harry J. Crawford M.D.				Eastern Shore State Hospital			
PHYSICIAN'S NAME (Type) Harry J. Crawford, M.D.				Cambridge, Maryland 10-22-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/60		22c. NAME OF CEMETERY OR CREMATORY Head of Christiana Cemetery, Newark, Del.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.				24a. REC'D BY REGISTRAR DATE OCT 26 '60		24b. REGISTRAR'S SIGNATURE Charles S. House	



11336

CERTIFICATE OF DEATH

11319

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Few Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. STREET ADDRESS <u>East New Market</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Eliz.</u> Last <u>Young Dockins</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 23, 1907</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Young</u>				14. MOTHER'S MAIDEN NAME <u>Emma V. Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes: no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>213-18-6030</u>		17. INFORMANT <u>Marcellus Dockins, East New Market, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u>	Month <u></u> Day <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>August 16, 1960</u> , to <u>October 6, 1960</u> , that I last saw the deceased alive on <u>October 6, 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>10-8-60</u>							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				M.D. <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>10-8-60</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/10/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) <u>Dorchester County, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Verber M. H. H. H.</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 24 hours after death.



11337

CERTIFICATE OF DEATH

11320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Few Hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Dockins</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx.</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Camper</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Marcellus Dockins, East New Market, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>October 22, 1960</u> to <u>October 29, 1960</u> , that I last saw the deceased alive on <u>October 29, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>10-31-60</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Williams</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 9 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11338

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11321

1. PLACE OF DEATH a. COUNTY Dorchester, CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Dunn Last Dunn		4. DATE OF DEATH Month 10 Day 19 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 19 Hours 60 Min 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY School Board	
11. BIRTHPLACE (State or foreign country) Caroline, Co. Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dunn		14. MOTHER'S MAIDEN NAME Ellen Tall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Edward Dunn., 418 Henry, St. Cambridge, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) ARTERIOSCLEROSIS DUE TO (c) CORONARY HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-24-58 , 19____, to 10-19-60 , 19____, that (I) (we) last saw the deceased alive on 10-18-60 , 19____, and that death occurred at ____ M., from the causes and on the date stated above			
22a. SIGNATURE <i>Albert E. Bunker</i>		22b. DATE SIGNED 10-21-60	
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M.D.		22d. ADDRESS 200 MARYLAND AVE, CAMBRIDGE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/1960.	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR 4 60	
25b. REGISTRAR'S SIGNATURE <i>W. S. Thomas</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

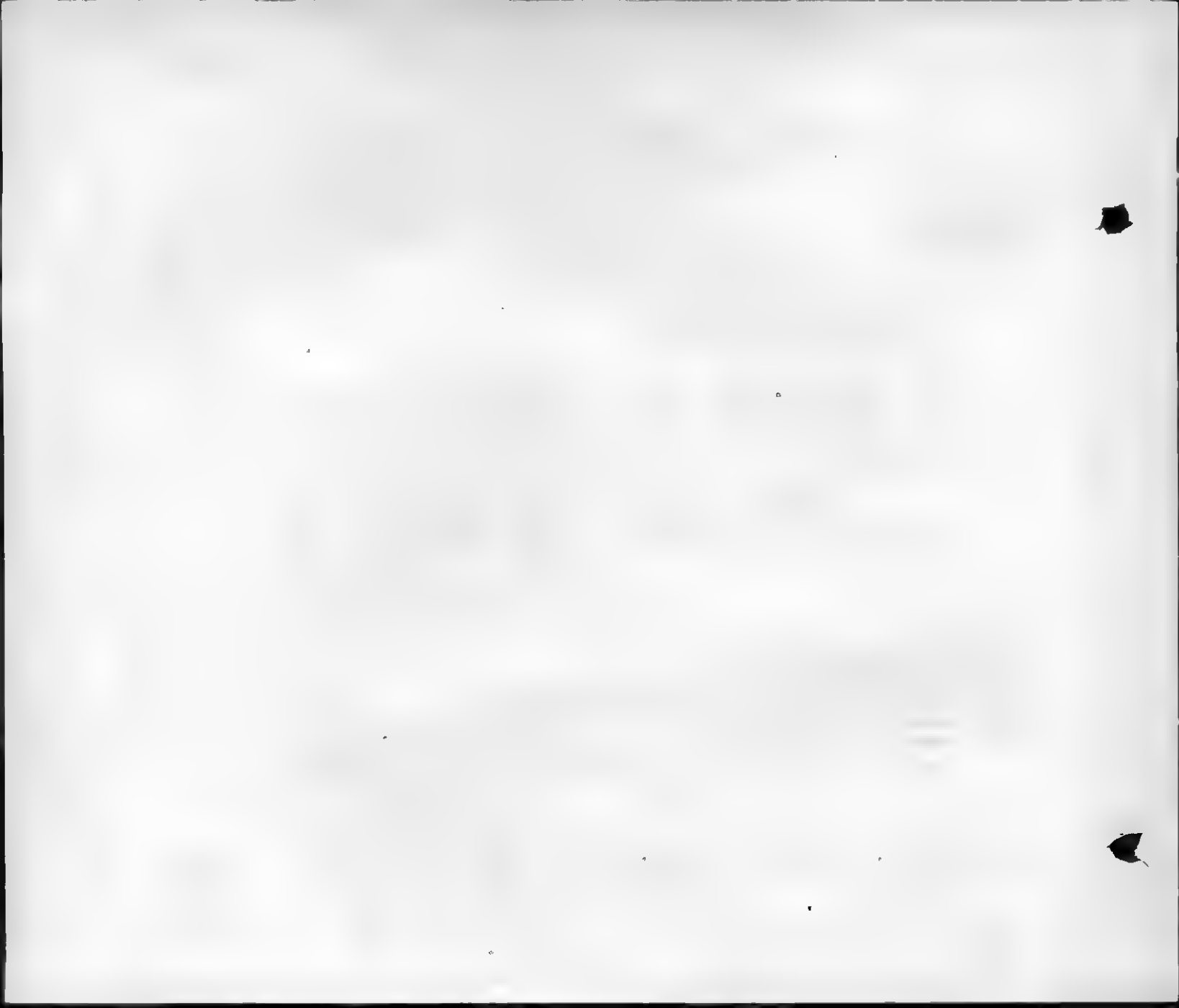
11339

CERTIFICATE OF DEATH

11322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>191 Washington Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lulu</u> Middle <u>Elizabeth</u> Last <u>Earles</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1904</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Earles</u>				14. MOTHER'S MAIDEN NAME <u>Susan Mariah Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-8938</u>		17. INFORMANT <u>Jessie Earles, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 1, 1960</u> , to <u>October 27, 1960</u> , that I last saw the deceased alive on <u>October 27, 1960</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>				DATE SIGNED <u>10-29-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert H. Spillane</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11340

CERTIFICATE OF DEATH

11323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				d. STREET ADDRESS 1 Moores Avenue Ext'd			
3. NAME OF DECEASED (Type or print) First Joyce Middle Edwards Last Edwards				4. DATE OF DEATH Month Oct. Day 19 Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1959	9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 4 Days Hours Min. 	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Warren Edwards				14. MOTHER'S MAIDEN NAME Ornie Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Ornie J. Edwards, Cambridge, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXEMIA 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE GASTRO-ENTERITIS DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 7 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour Month Day 19 Year p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 10/11 , 19 60 , to 10/18 , 19 60 , that I last saw the deceased alive on 10/18 , 19 60 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 RACE ST DATE SIGNED 10/21/60							
ACTUAL SIGNATURE Alfred R. Maryanov M.D.		PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV CAMBRIDGE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/21/1960	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. McLaughlin ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR DATE NOV 9 '60		24b. REGISTRAR'S SIGNATURE Charles L. Kline	



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

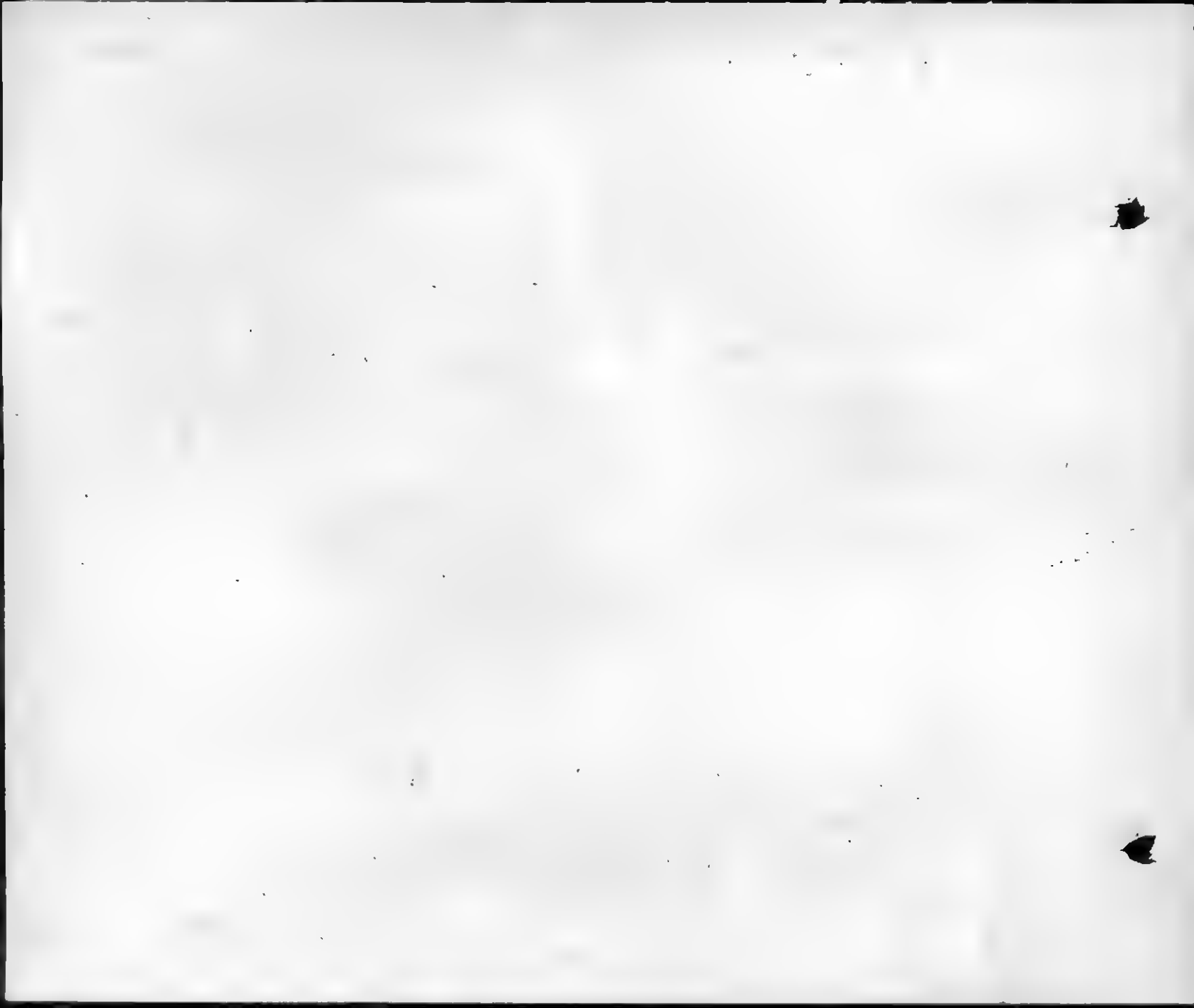
CERTIFICATE OF DEATH

11360

11324

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dor</u> b. COUNTY <u>Ind</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shulock</u>				c. LENGTH OF STAY IN 1b <u>4 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Penrose Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lizzie Spear Ellis</u>				4. DATE OF DEATH <u>10/8/1960</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/7/1873</u>	
9. AGE (In years last birthday) <u>87</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress - Ret</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Spear</u>				14. MOTHER'S MAIDEN NAME <u>Lovica Shorty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>Ms Maude Venable Shulock Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u> DUE TO <u>Generalized arteriosclerosis</u> DUE TO <u>Right Cerebral Hemorrhage & Left parietal lobe</u> DUE TO <u>Right Cerebral Hemorrhage & Left parietal lobe</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 week</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>15 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> <u>1957</u> to <u>10-8</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>10-7</u> <u>1960</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Stacy Blumner</u> M.D.				22b. DATE SIGNED <u>10-11-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. H. Blumner</u>				22d. ADDRESS <u>Proctor, Ind</u>			
23a. MANNER OF CREMATION <u>Burial</u> (Specify)				23b. DATE THEREOF <u>10/12/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Freemans</u>				23d. LOCATION (City, town, or county) <u>Shapton Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter S. Helwig, East New Market</u>				25a. REC'D BY REGISTRAR <u>OCT 17 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11341 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

11325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
c. LENGTH OF STAY IN Ia <u>Life</u>				d. STREET ADDRESS <u>11 Dobson Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Dobson Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John James Ennals</u>				4. DATE OF DEATH Month Day Year <u>Oct. 23. 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Ennals</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Burruoghs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) [If yes, give war or dates of service] <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ruth Ennals, Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>199-2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 1, 1960</u> , to <u>October 23, 1960</u> , that I last saw the deceased alive on <u>October 23, 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md. 10-25-60</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/27/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wagh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



11342

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

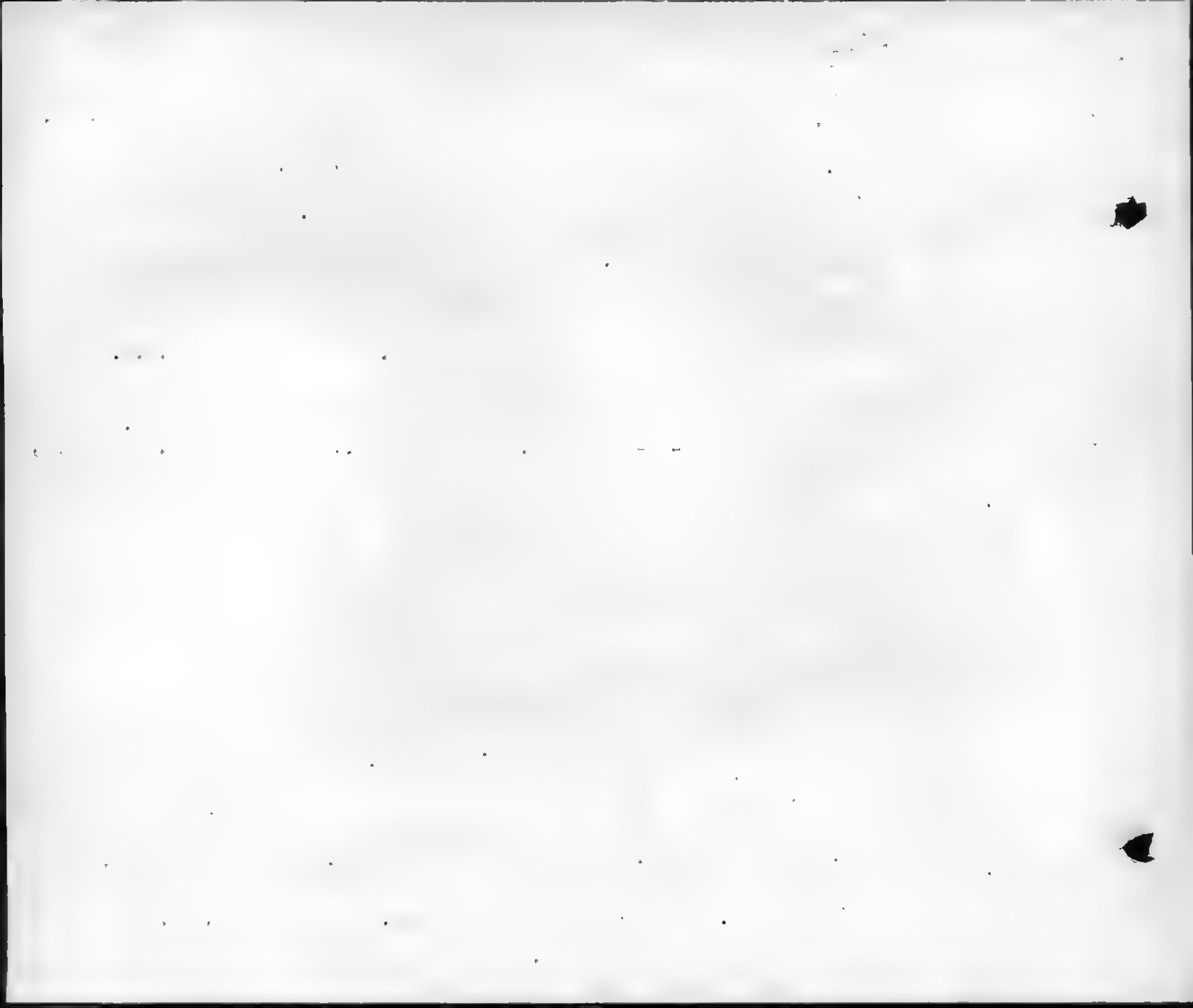
CERTIFICATE OF DEATH

11326

1 PLACE OF DEATH a. COUNTY Dorchester, Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. c. LENGTH OF STAY IN lb 5 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland. d. STREET ADDRESS 307 Henry, Street. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wilfred T. Gatton		4. DATE OF DEATH Month Day Year 10/ 11 19 60	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1879
9. AGE (In years lost birthday) yrs 81		10. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Maryland.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Gatton		14. MOTHER'S MAIDEN NAME Jennie Gatton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 214-10-0973	
17. INFORMANT Mrs. Stella Gatton.		Address 307 Henry, St. Cambridge, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accident 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Oct. 8, 1960 to Oct. 11, 1960 that (I) (we) last saw the deceased alive on Oct. 11 1960 , and that death occurred at 10M , from the causes and on the date stated above			
22a SIGNATURE John Mace Jr.		22b DATE SIGNED 10/13/60	
22c PHYSICIAN'S NAME (Type) Dr. John Mace Jr.		22d ADDRESS 5 Church St. Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/14/1960.	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memoria l Park	23d. LOCATION (City, town or county) (State) Cambridge, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a REC'D BY REGISTRAR OCT 17 '60	25b REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



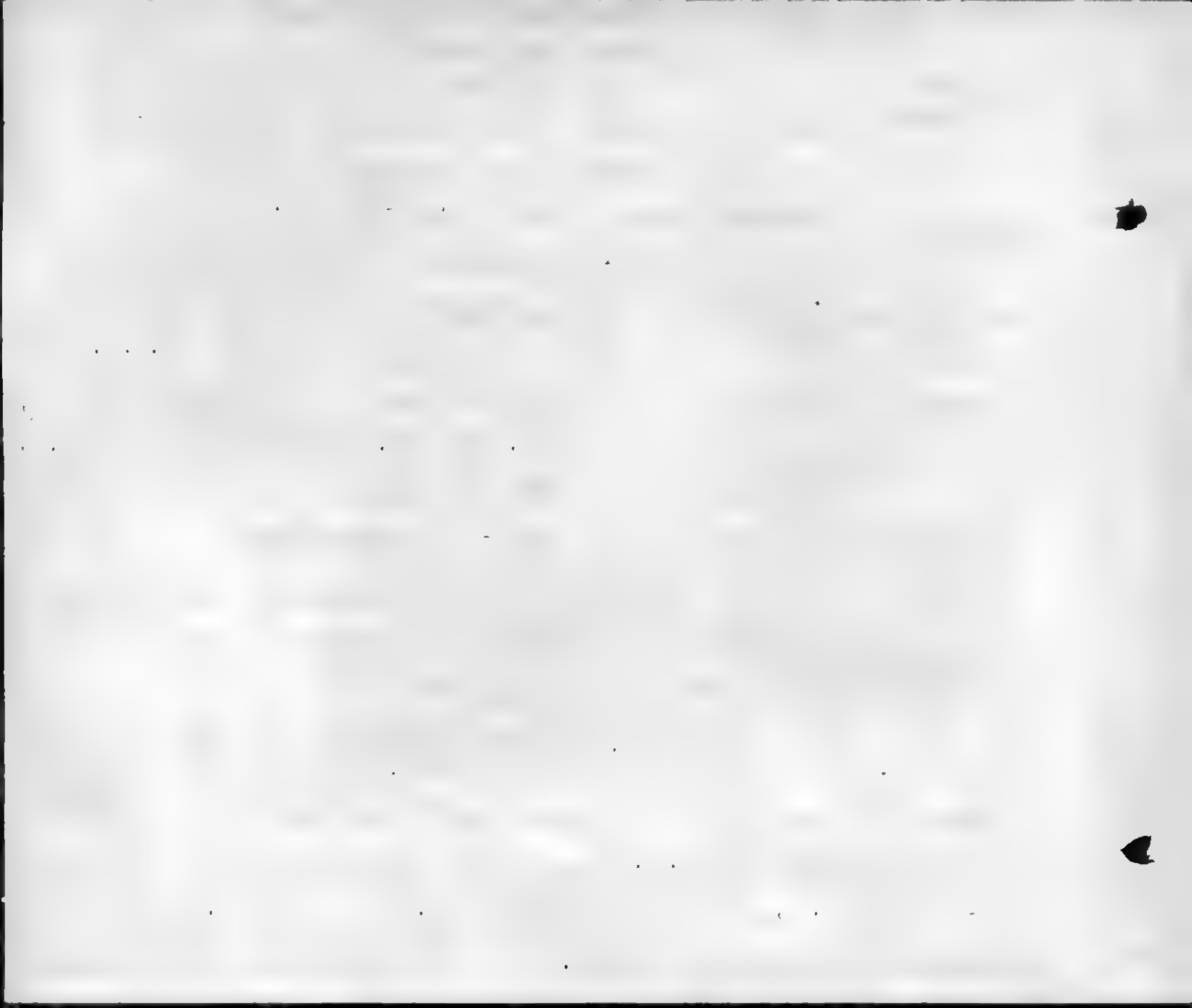
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11343 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
 Items 1, 7, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60 et
CERTIFICATE OF DEATH

11327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				d. STREET ADDRESS 2602 N. Pershing Dr.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle W. Last Goodsell				4. DATE OF DEATH Month Oct Day 28 Year 1960			
5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 28 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairyman		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-03-5297		17. INFORMANT Mrs. George T. Costello		Address 4454 Greenwich Pk'y Washington 7, D.C.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Mesenteric Thrombosis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-vascular-Renal Disease DUE TO (c) Arteriosclerosis, Generalized							INTERVAL BETWEEN ONSET AND DEATH 30 hours 10 days + 10 days +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic & Acute Cardiac & Renal Failure, 10 days +							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 17th , 19 60 , to Oct. 28th , 19 60 , that I last saw the deceased alive on Oct. 28th , 19 60 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Eldridge H. Wolff M.D.				ADDRESS (Street, city or town, state) Cambridge, Maryland		DATE SIGNED 10/28/60	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.				(15 Locust Street)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1960		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE NOV 3 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kiser			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

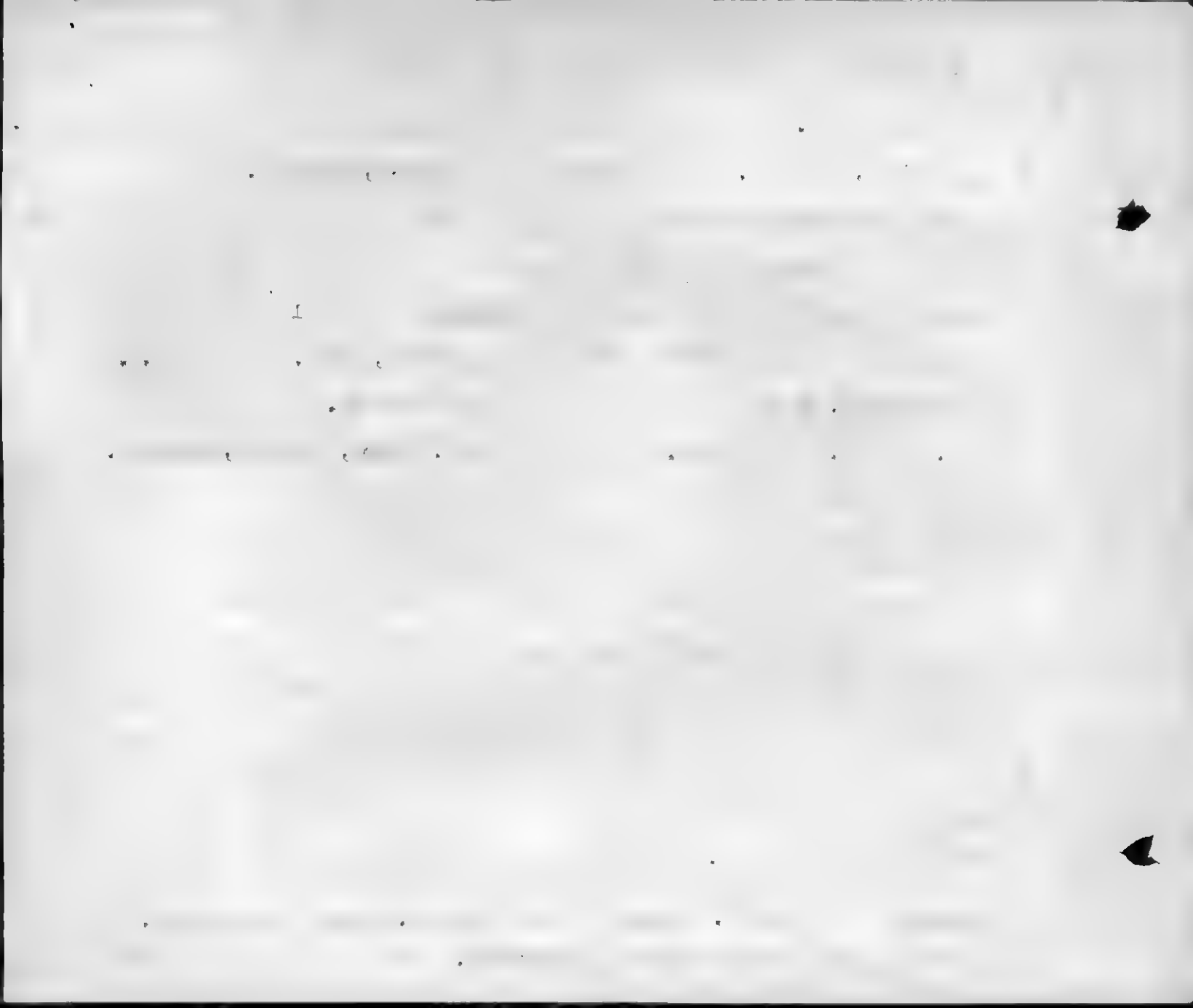
VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT

11344
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12502

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN b 10 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e. STREET ADDRESS Linkwood, Maryland.	
3. NAME OF DECEASED (Type or print) Lorraine Duck Harmon		4. DATE OF DEATH Month 10 Day 29 Year 1960	
5 SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/1909	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 10 Days 29 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Case Worker		10b. KIND OF BUSINESS OR INDUSTRY Welfare Board	
11. BIRTHPLACE (State or foreign country) Greenville, Texas.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Duck		14. MOTHER'S MAIDEN NAME Ollie Duck Sr.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. No.	
17. INFORMANT William F. Harmon, Linkwood, Maryland.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. _____			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/31/60			
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 10/31/1960.			
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Maryland.			
22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Maryland.			
24a. REC'D BY REGISTRAR DATE NOV 9 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

11345 **MARYLAND STATE DEPARTMENT OF HEALTH**
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11328

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland Hospital, D.C.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Taylors Island</u> d. STREET ADDRESS _____		
3. NAME OF DECEASED (Type or print) <u>John Henry Hooper</u>			4. DATE OF DEATH <u>Oct. 12, 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1896</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Hooper</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Travers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>217-09-129</u>		17. INFORMANT <u>Mrs. Gertrude Hooper Taylors Island,</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20d. (City or town) _____		20e. (County) _____		20f. (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. _____		DATE SIGNED <u>10/15/60</u>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Taylors Island Cemetery</u>	
22d. LOCATION (City, town, or country) <u>Taylors Island, Dor. Md.</u>		22e. (State) _____			
23. FUNERAL DIRECTOR <u>Herbert St Clair Cambridge, Md.</u>		ADDRESS _____		24a. RECEIVED BY REGISTRAR <u>OCT 18 60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>		DATE _____			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

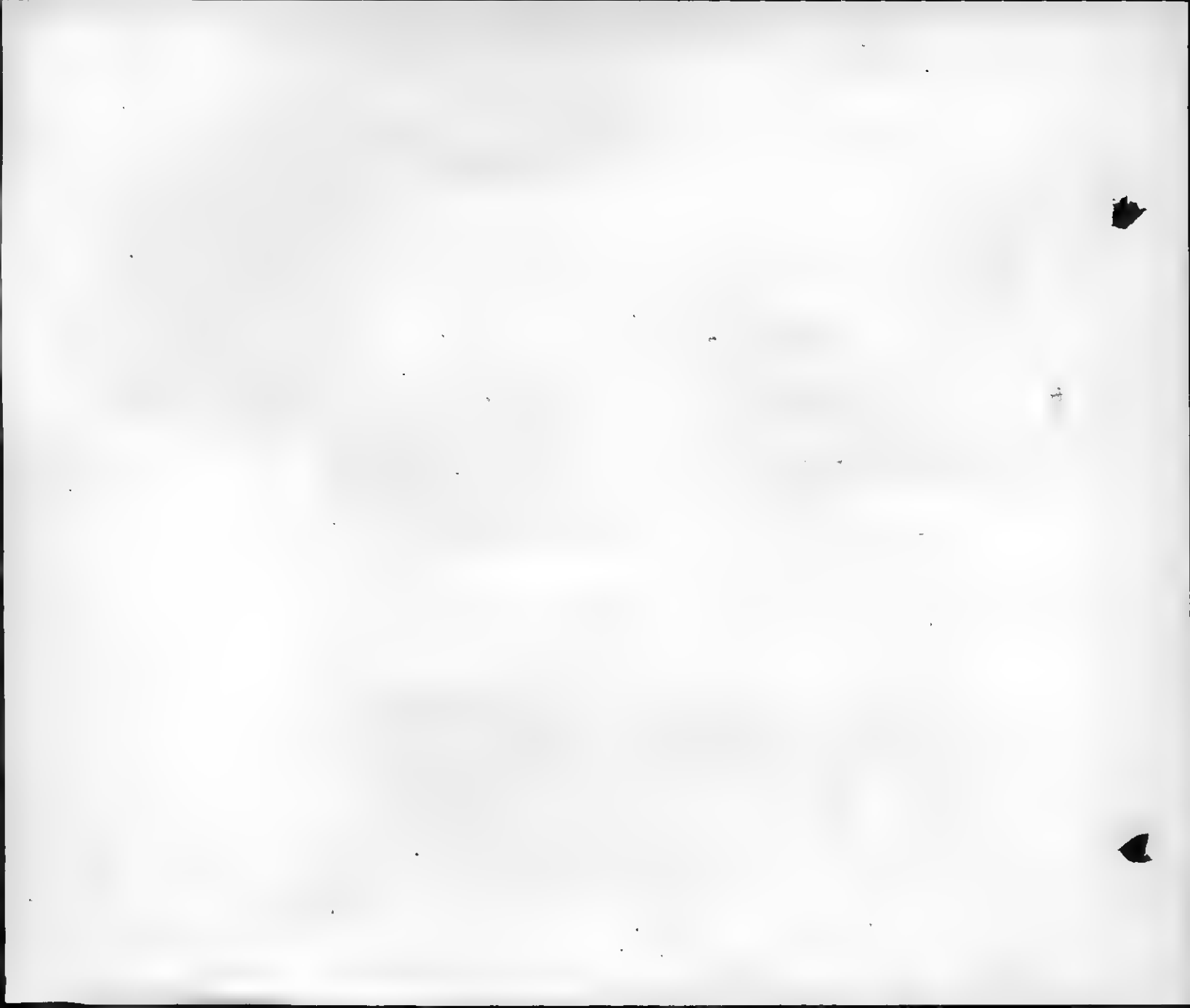
11361

11329

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Call life</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Call life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clive</u> First <u>Marion</u> Middle <u>Haddon</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/9/1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Haddon</u>				14. MOTHER'S MAIDEN NAME <u>Marion Haddon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Dr. H. H. Haddon, Baltimore, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Obesity</u> (c) <u>Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>10/17</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> to <u>10/17</u> 19 <u>60</u> ; that (I) (we) last saw the deceased alive on <u>10/17</u> 19 <u>60</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>W. H. Haddon</u>				22b. DATE SIGNED <u>10/20/60</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H. Haddon</u>	
22d. ADDRESS <u>Cambridge Md</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/20/60</u>		<u>Call life</u>		<u>Call life</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Call life</u> ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Call life</u>				<u>Call life</u>		<u>Call life</u>	

OCT 27 '60



11346

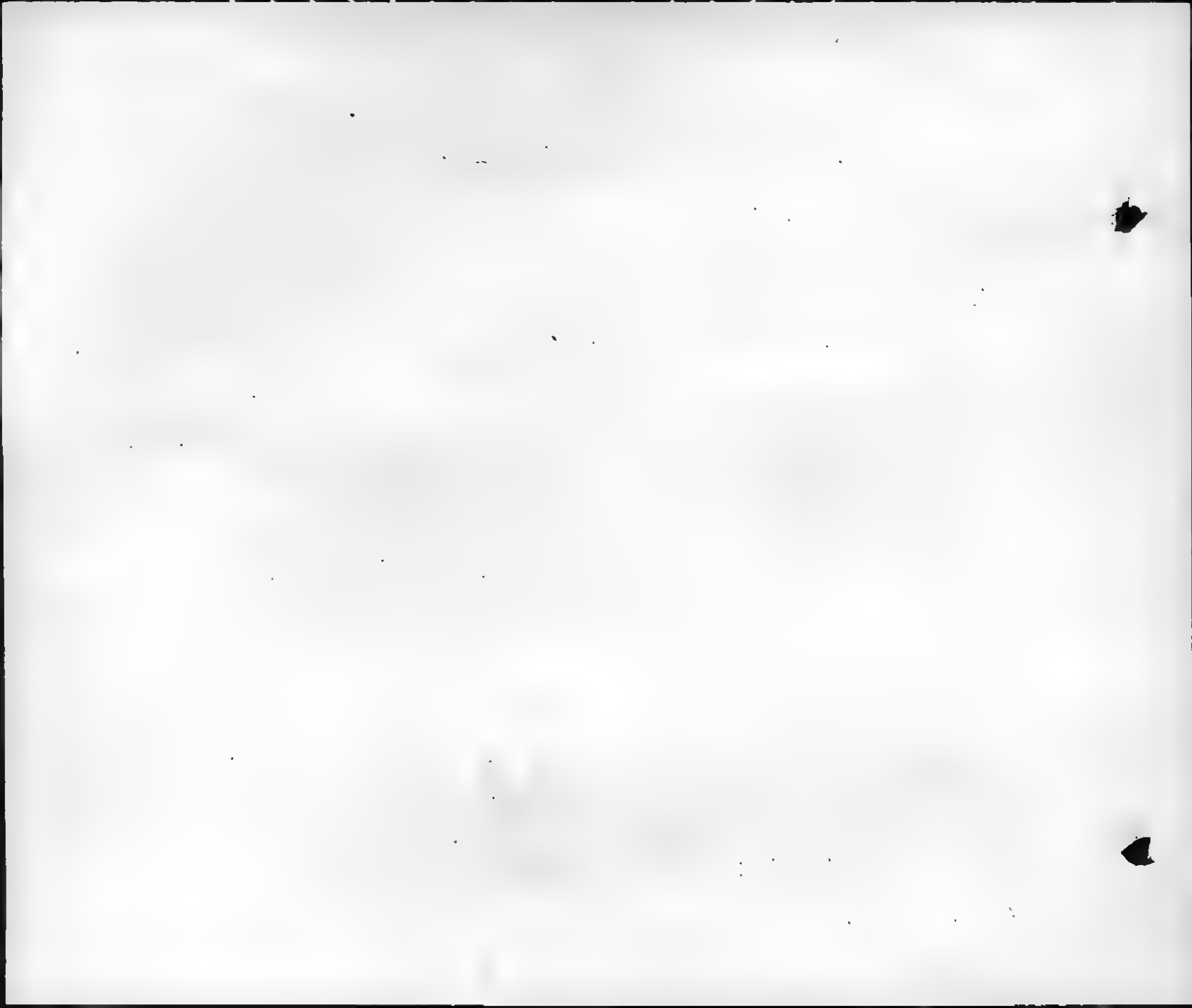
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11330

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Keloid</u> First <u>Keloid</u> Middle <u>House</u> Last <u>man</u>			4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/1884</u>	9. AGE (In years last birthday) <u>76</u> yrs	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Lawrence H. Haysman</u>			
14. MOTHER'S MAIDEN NAME <u>Esther Stewart</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>Mr. Marie Boulton Patterson</u>				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Coronary Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 days</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> , 19 <u>60</u> to <u>10/27</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> , 19 <u>60</u> and that death occurred at <u>5:00</u> P.M. from the causes and on the date stated above							
22a. SIGNATURE <u>Lawrence Maryanov</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>10/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>				22d. ADDRESS <u>Cambridge, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City, town, or county) (State) <u>Cambridge Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haysman</u> ADDRESS <u>East New Market</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				DATE <u>NOV 3 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove/carry papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11347
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

11331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>213 Cedar Street</u>		e. STREET ADDRESS <u>213 Cedar Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Manokey</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Manokey</u>		14. MOTHER'S MAIDEN NAME <u>Millie Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO <u>212-16-7688</u>	
17. INFORMANT <u>George Manokey, Baltimore, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, <u> </u> Day, <u> </u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1960</u> , to <u>October 26, 1960</u> , that I last saw the deceased alive on <u>October 26, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>10-27-60</u>			
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		M.D. <u>227 Pine St-Cambridge, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/30/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old Field Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. St. Clair Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE NOV 9 '60			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rhodesdale			c. LENGTH OF STAY IN 1b 18 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Rhodesdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Wesley Lofland				4. DATE OF DEATH Month October Day 11 Year 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 220-05-1874		17. INFORMANT Mrs. Edna Lofland		Address RFD-Rhodesdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1013/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1960		22c. NAME OF CEMETERY OR CREMATORY Johns Cemetery		22d. LOCATION (City, town, or county) (State) Caroline County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son				ADDRESS Federalsburg, Md.		24a. REC'D BY REGISTRAR DATE OCT 18 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Frank				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the registrar. Give Page 5 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11363

CERTIFICATE OF DEATH

11333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Church Creek</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Church Creek</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Matney</u> Last <u>Matney</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 23, 1868</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR: Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Matney</u>				14. MOTHER'S MAIDEN NAME <u>Mariah Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Elisha Matney, Cambridge, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>January 1, 1958</u> , to <u>October 24, 1960</u> , that I last saw the deceased alive on <u>October 24, 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>227 Pine St-Cambridge, Md.</u> <u>10-25-60</u> PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meekins Neck Ceme.</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

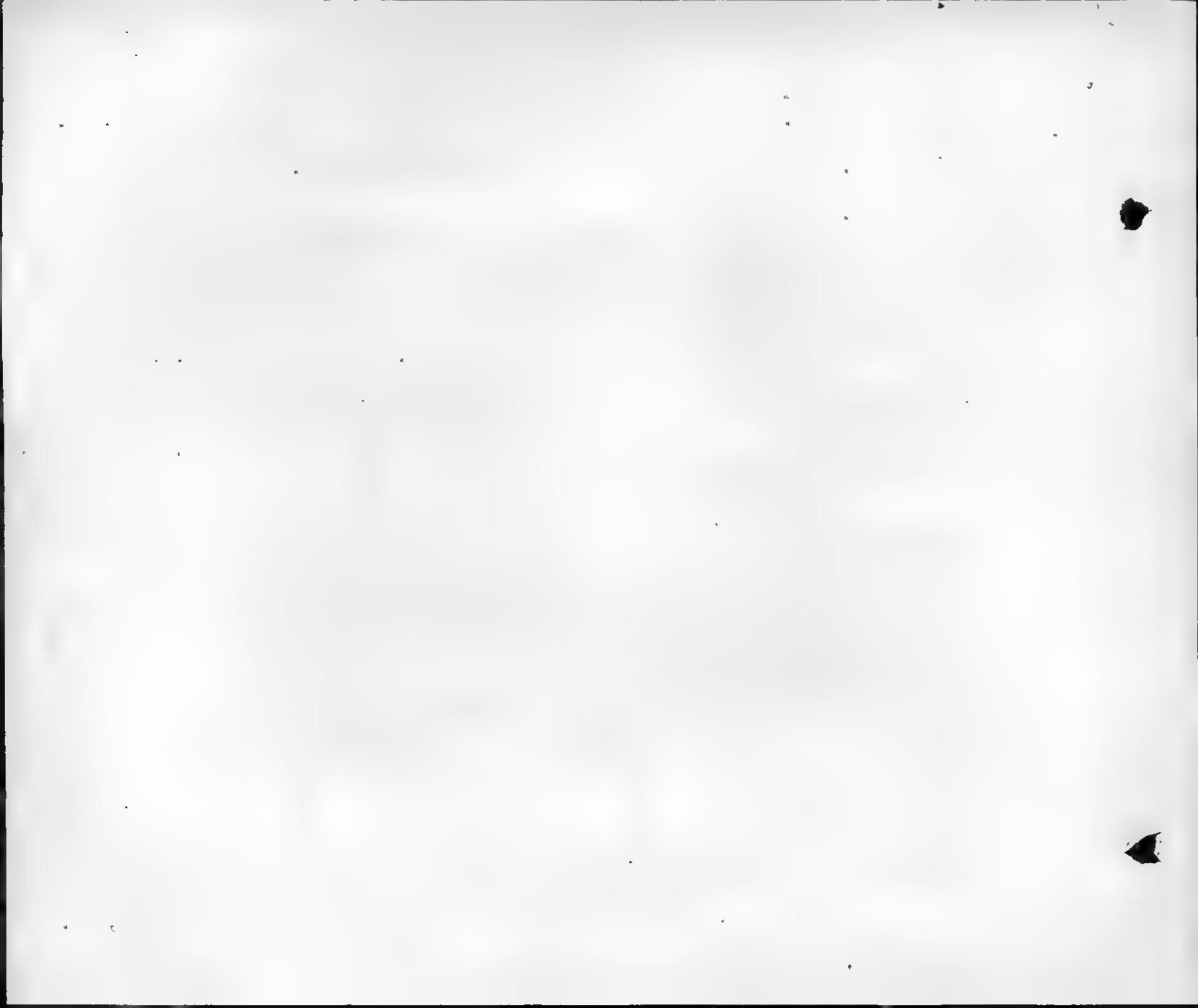
VR A15 (4)
15M 11/59

11345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11364

1 PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>503 Race, St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willie Gore Meredith</u>		4. DATE OF DEATH Month Day Year <u>10 17 1960</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/1865</u>
9 AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>10 17 1960</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Gore</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Gore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Miss Ruby Meredith, 503 Race, St. Cambridge, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> 431 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TOXIC MYOCARDITIS</u> DUE TO (c) <u>WIDESPREAD DECUBITUS ULCERS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>6/10</u> <u>1950</u> to <u>10/17</u> <u>1960</u> that (I) (we) lost saw the deceased alive on <u>10/17</u> <u>1960</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>W. H. Flanks</u>		22b. ADDRESS <u>(CAMBRIDGE MARYLAND)</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Flanks, M.D.</u>		22d. ADDRESS <u>(CAMBRIDGE MARYLAND)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town, or county) (State) <u>Cambridge East New Market, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u> <u>Cambridge, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 4 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Flanks</u>		25c. REGISTRAR'S SIGNATURE	



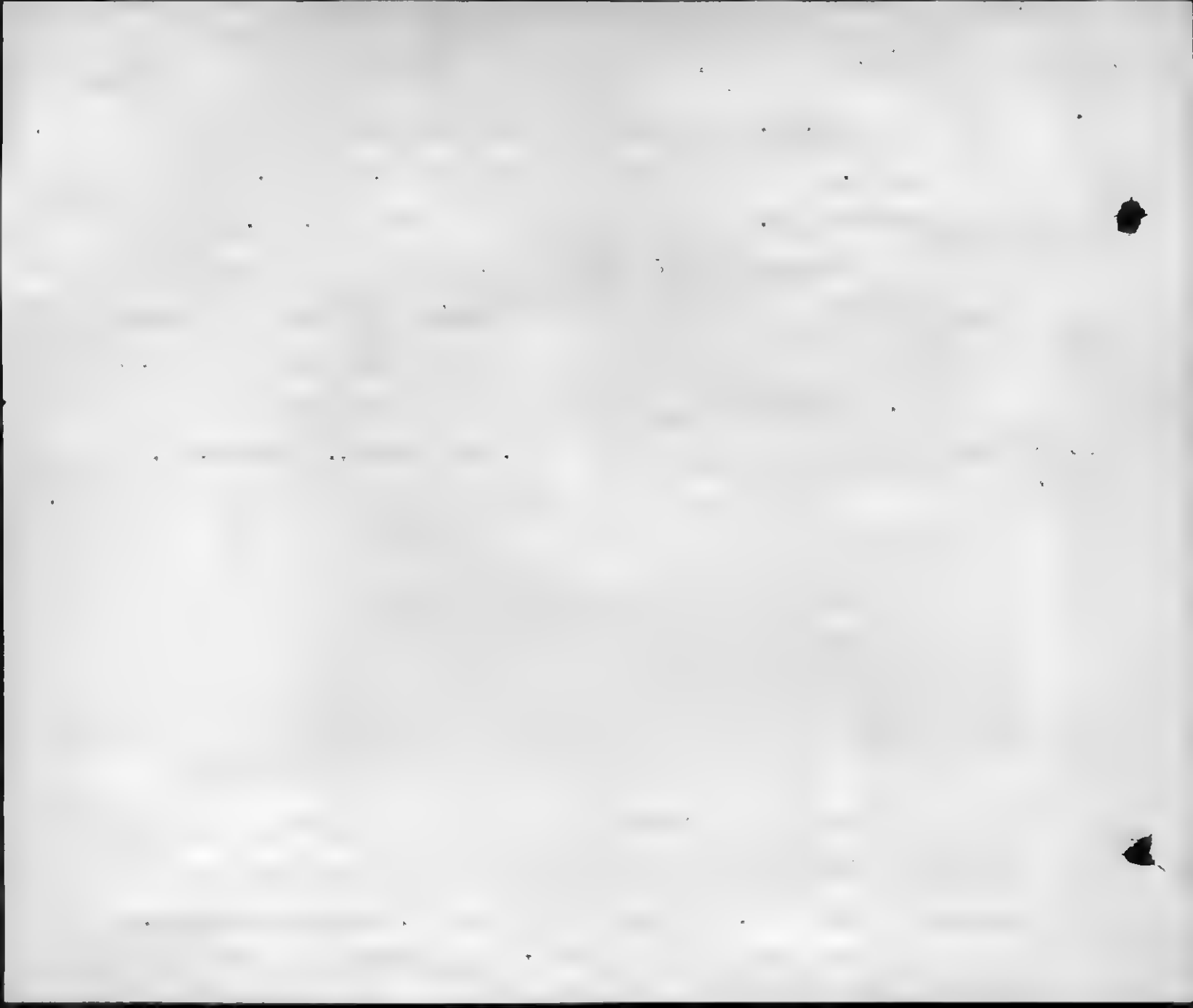
11349

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11335

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) trappe			
c. LENGTH OF STAY IN 1b 13 da				d. STREET ADDRESS Route II			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Andrew Middle Mills Last Mills				4. DATE OF DEATH Month 10 Day 14 Year 1960			
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1915	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 19 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saintor				10b. KIND OF BUSINESS OR INDUSTRY School			
13. FATHER'S NAME Kevin Mills				14. MOTHER'S MAIDEN NAME Johanna Barnett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 163-18-2269			
17. INFORMANT Alice Mills Trappe				Address trappe			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompression 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October 1, 1960 to Oct 14, 1960 , that (I) (we) last saw the deceased alive on Oct 14, 1960 , and that death occurred at _____ M. from the causes and on the date stated above.							
22a. SIGNATURE J. Edwin Fassett				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.				22d. ADDRESS 227 Pine St-Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/60		23c. NAME OF CEMETERY OR CREMATORY trappe Cem		23d. LOCATION (City, town, or county) (State) trappe Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James D. Quinn				25a. REC'D BY REGISTRAR md.		25b. REGISTRAR'S SIGNATURE Charles L. Thomas	
DATE OCT 24 '60							

March 15, 1882



Reg. Dist. No.

MEDICAL CERTIFICATION

VS AIS (4)
15M 9/55



TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

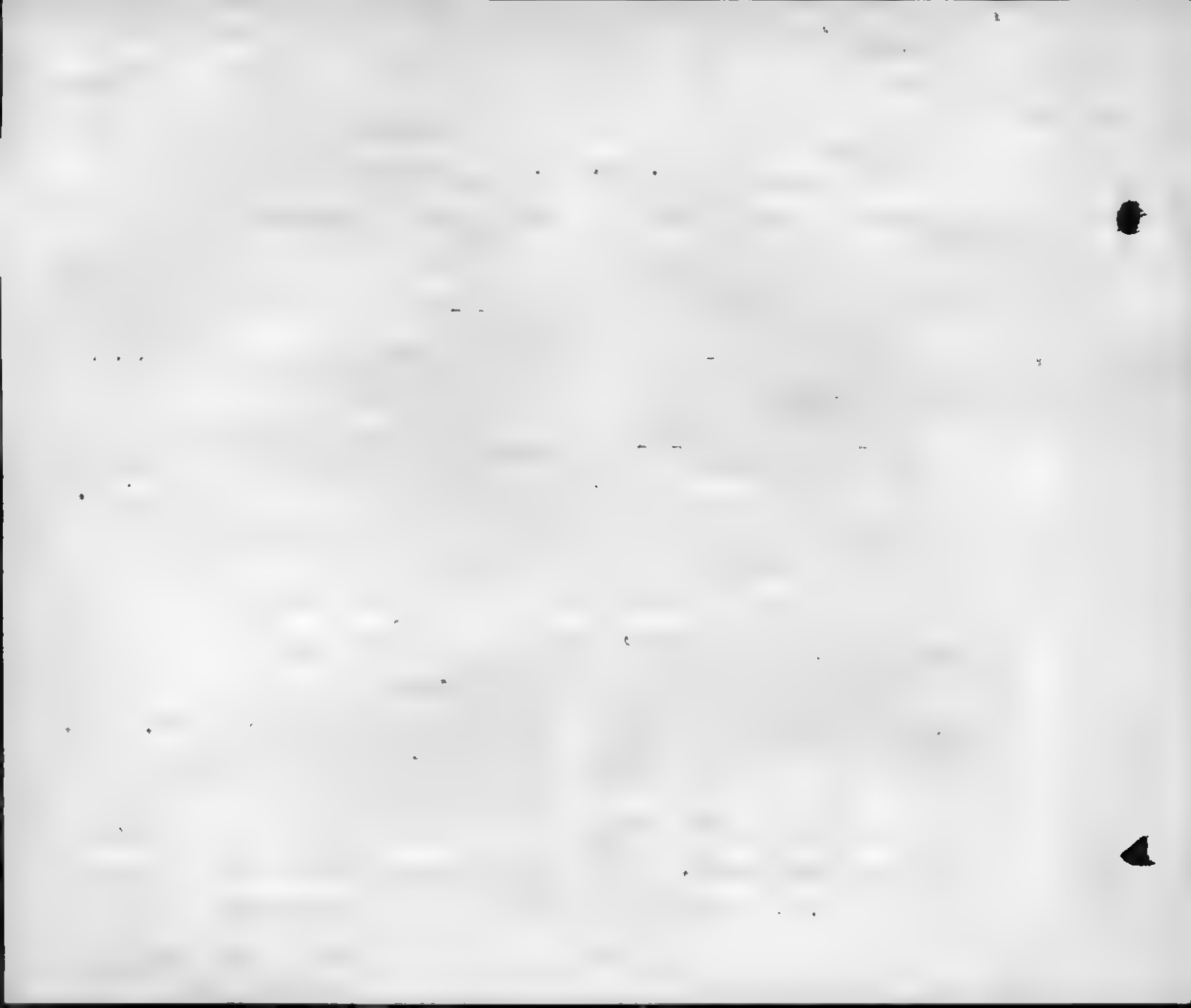
1
FOR STATE
HEALTH DEPT

M

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
11364													
11358													
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>1yr. 8mos. 7das.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Res. since before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> d. STREET ADDRESS <u>219 Morris Avenue</u>							
3. NAME OF DECEASED (Type or print) <u>Elma Edgell Oertel</u>						4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1960</u>							
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>10-5-81</u>							
9. AGE (In years last birthday) <u>79</u> yrs.						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesclerk</u>							
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Edgell</u>						14. MOTHER'S MAIDEN NAME <u>Emma Edgell</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>						16. SOCIAL SECURITY NO. <u>217-16-9220</u>							
17. INFORMANT <u>Eastern Shore State Hospital Records</u>						Address <u>Records</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fracture neck femur, left</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell to floor.</u>													
20c. TIME OF INJURY Month, Day, Year <u>4/23/60</u> Hour a.m. <u>10 AM</u> p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>						20f. (City or town) <u>Cambridge</u> (County) <u>Dor.</u> (State) <u>Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type) <u>John Mace Jr.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/6/60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>Oct. 8, 1960</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>						22d. LOCATION (City, town, or country) (State) <u>Federalburg, Maryland</u>							
23. FUNERAL DIRECTOR <u>J. J. FRAMPTON & SON</u>						24a. REC'D BY REGISTRAR <u>FEDERALSBURG</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							
V.S. A15ME 5M 7/59						DATE <u>OCT 10 '60</u>							



FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

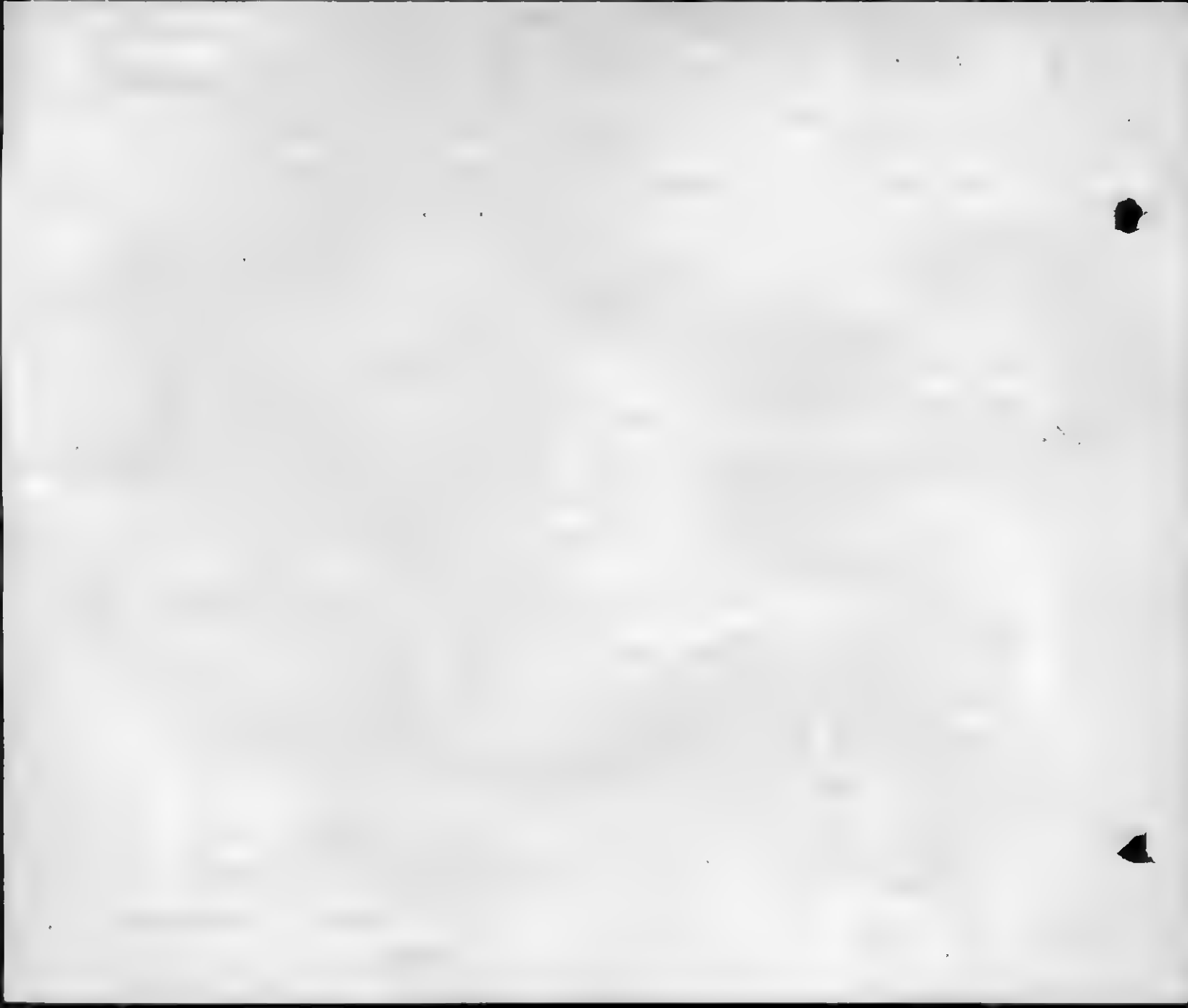
VS. A15ME
SM 7/59

11332 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11330

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bural Cambridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				e. STREET ADDRESS <u>R.F. 3</u>			
3. NAME OF DECEASED (Type or print) <u>Willie</u> <u>Phillips</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>4,</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/16/1920</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmhand</u>		9. AGE (In years last birthday) <u>40</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
13. FATHER'S NAME <u>Macon Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Stroudamire</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>				16. SOCIAL SECURITY NO. <u>RT.3 Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, general</u> <u>585X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cholecystitis</u> (c) <u>Cholecystitis</u> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mac Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Mac Jr.</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/10/60</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cambridge, Dorchester, Md.</u>	
23. FUNERAL DIRECTOR <u>St. Clair Funeral</u>				24b. REGISTRAR'S SIGNATURE <u>C. L. S. Turner</u>			
ADDRESS <u>Cambridge, Md.</u>				DATE <u>OCT 18 '60</u>			

MEDICAL CERTIFICATION



11365
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No. 11340

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 201 HAZEL ST	
3. NAME OF DECEASED (Type or print) Forde First W Middle Pritchett Last		4. DATE OF DEATH Oct 22 1960 Month Oct Day 22 Year 1960	
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 1 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Waterman	9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Hospital records		Address Cambridge	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 422.2 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 18 , 19 60 , to Oct 22 , 19 60 , that I last saw the deceased alive on Oct 21 , 19 60 , and that death occurred at 12:05 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED 10-22-65 ACTUAL SIGNATURE Thomas J. Dredge M.D. PHYSICIAN'S NAME (Type) Thomas J. Dredge MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) B	22b. DATE THEREOF 10/24/1960	22c. NAME OF CEMETERY OR CREMATORY St. Thomas Church Yard	22d. LOCATION (City town, or county) (State) Bishops Head, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR Cambridge	24b. REGISTRAR'S SIGNATURE Nov 4 '60

1954

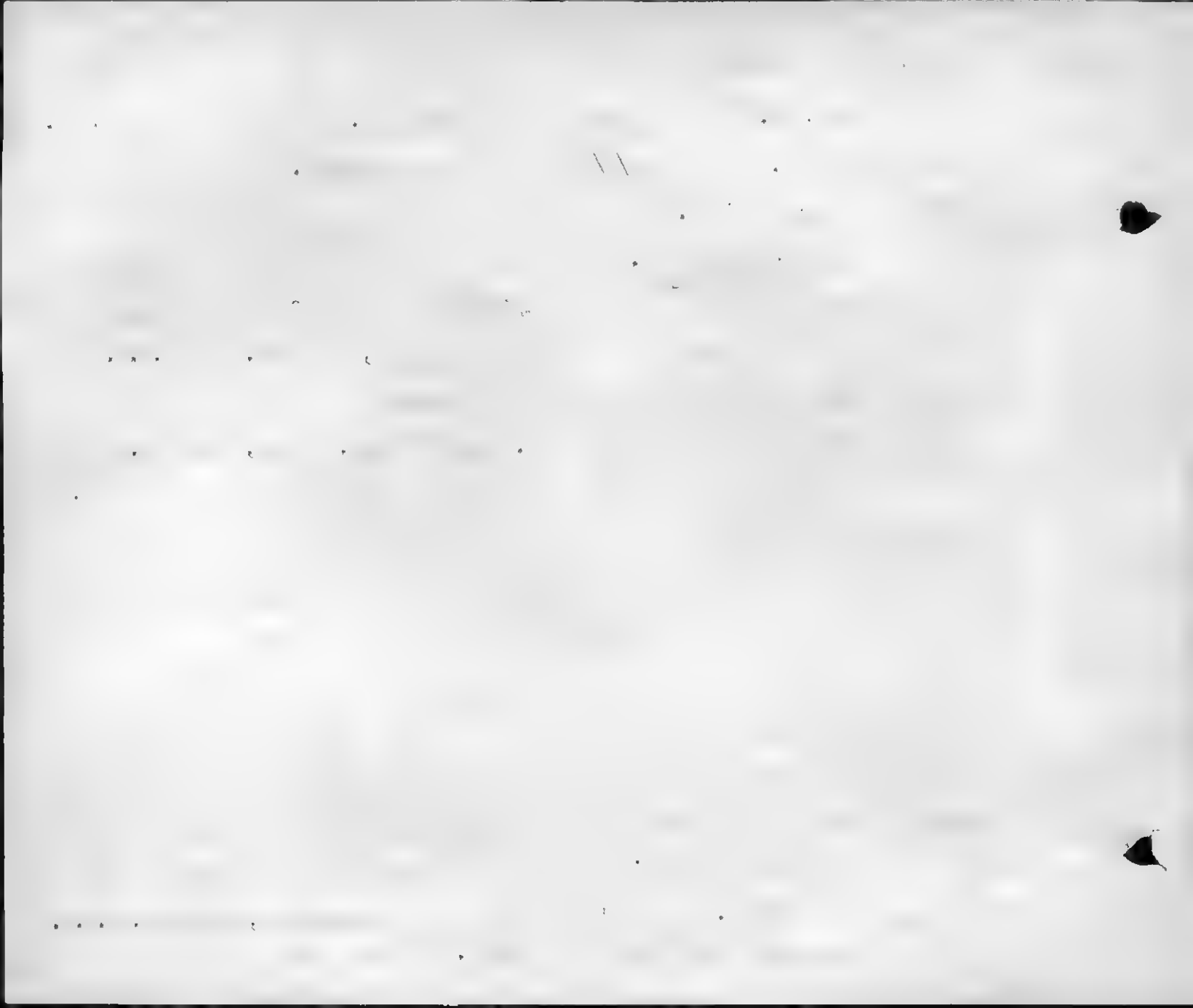
1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11341

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm. strsn) a. STATE Maryland. b. COUNTY Dorchester, Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Husdon, Maryland.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital.		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Roscoe R. Rauark		4. DATE OF DEATH 10 26 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/22/1897	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) James Island, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus Rauark		14. MOTHER'S MAIDEN NAME Ida Frazier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO No	
17. INFORMANT Mrs. Roscoe Rauark, Husdon, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/31/60 DATE SIGNED Address (Street, city, town, or county) (State)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/1960.	
22c. NAME OF CEMETERY OR CREMATORY Spedden's Cemetery		22d. LOCATION (City, town, or country) (State) Cambridge, Maryland R.F.D.	
23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Maryland.		24a. REC'D BY REGISTRAR NOV 9 '60	
24b. REGISTRAR'S SIGNATURE Orlough & Thomas			



11366

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11342

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS 205 LIBERTY ST			
3. NAME OF DECEASED (Type or print) First THEODORE Middle SHEA Last				4. DATE OF DEATH Month OCT. Day 10 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 15, 1891	
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER				10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MICHAEL JAMES SHEA				14. MOTHER'S MAIDEN NAME MARY DOWD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 215-01-5810		17. INFORMANT HOSPITAL RECORD Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA 491X DUE TO Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG. 28, 1958 to OCT. 10, 1960 , that (I) (we) last saw the deceased alive on OCT. 10, 1960 , and that death occurred at 6:10 PM , from the causes and on the date stated above							
22a. SIGNATURE Ettore De Filippis				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED OCT. 10, 1960	
22c. PHYSICIAN'S NAME (Type) ETTORE DE FILIPPIS				22d. ADDRESS EASTERN SHORE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF OCT 13 - 60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION (City, town, or county) (State) In Eastern Shore Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James H. Bata Jr. of Bata Bros. Centerville, Md.				25a. REC'D BY REGISTRAR DATE OCT 13 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11354

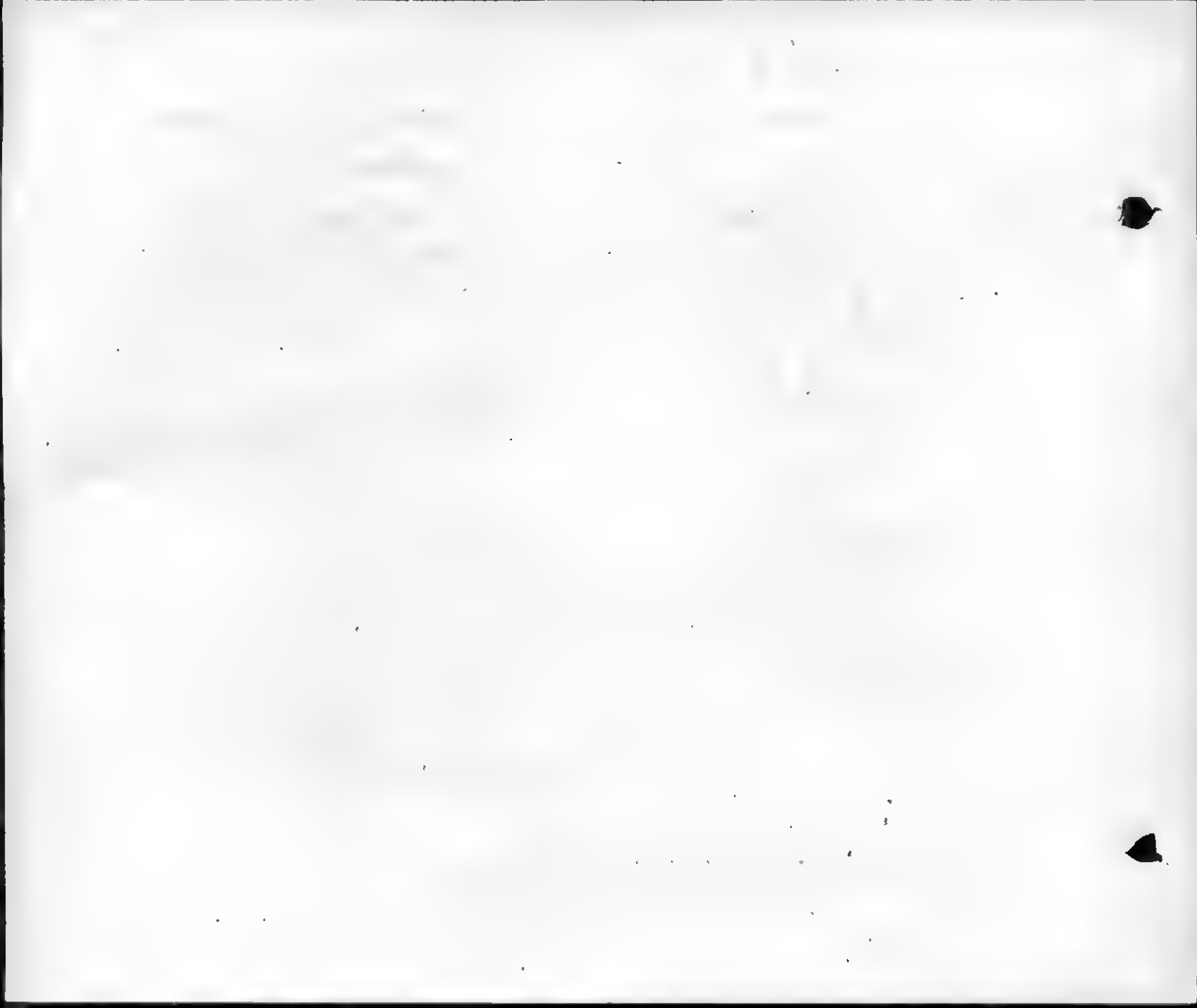
CERTIFICATE OF DEATH

11343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 60 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 253 Race street				d. STREET ADDRESS 253 Race street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sadie Middle Stewart Last Simmons				4. DATE OF DEATH Month October Day 10 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1871		9. AGE (In years last birthday) 89 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lakesville, Dor., Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred E. Stewart				14. MOTHER'S MAIDEN NAME Mary Frances Foxwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Informant		Address Miss Lowene Simmons, 253 Race St., Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHO PNEUMONIA - 3 days duration.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-11-45 , 19__ to 10-10-60 , 19__, that I last saw the deceased alive on 10-9-60 , 19__, and that death occurred at 5:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED 10-10-60							
ACTUAL SIGNATURE <i>Albert E. Bunker</i>		M.D. 200 Maryland Avenue					
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		CAMBRIDGE, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12, 1960		22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert R. Shores</i>				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE OCT 13 '60	
						24b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



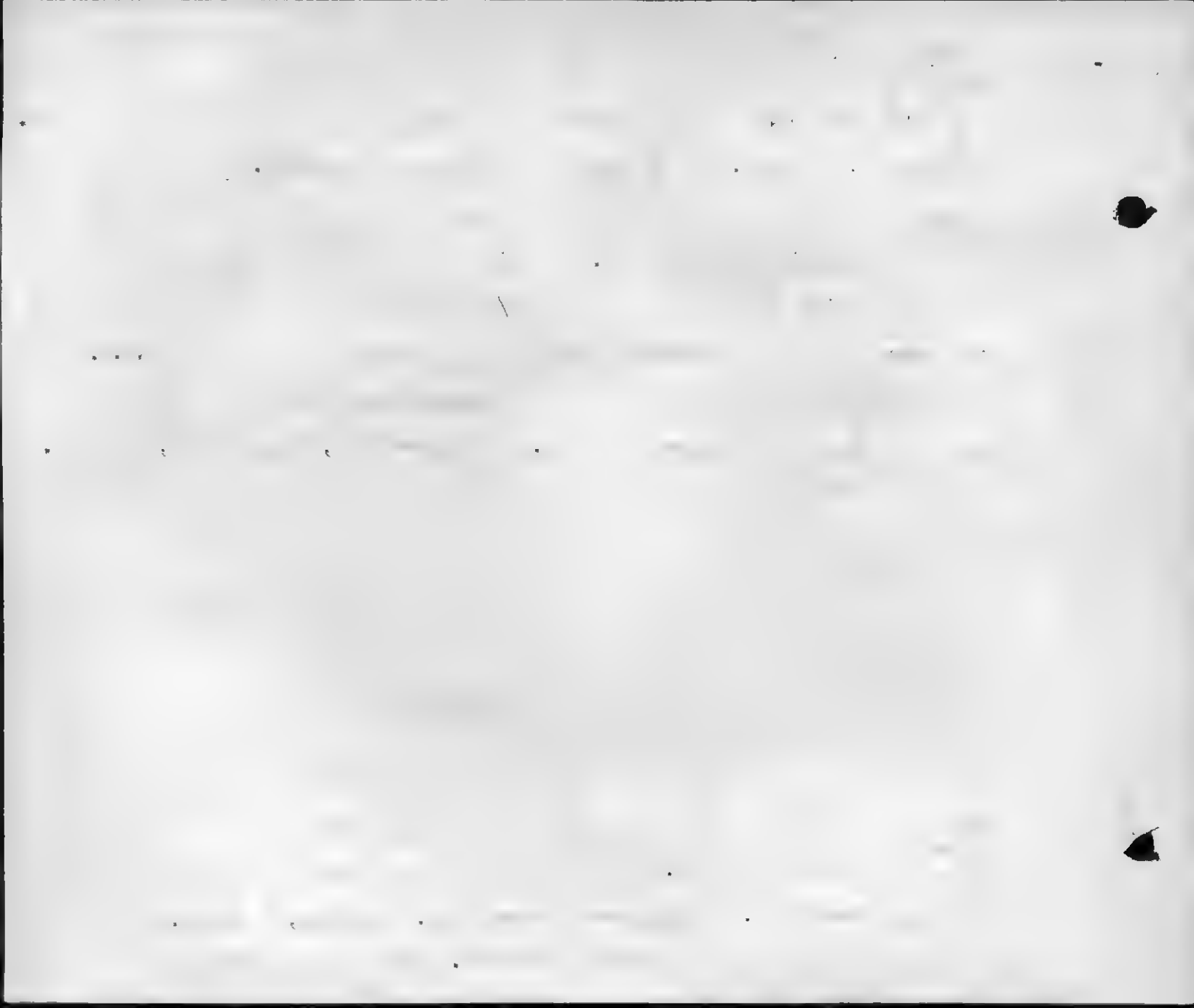
FOR-STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

11367 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11344

1. PLACE OF DEATH a. COUNTY Dorchester, Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg, Maryland. c. LENGTH OF STAY IN b. 25 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				2. USUAL RESIDENCE (Where deceased lived, if institution: Res. since before admission) a. STATE Maryland b. COUNTY Dorchester, Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg, Maryland. d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) William D. Smith				4. DATE OF DEATH Month 10 Day 29 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/25/1973	
9. AGE (in years last birthday) 87 yrs.				10. AGE (in years last birthday) 87 yrs.		11. AGE (in years last birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper				10b. KIND OF BUSINESS OR INDUSTRY General Mercantile			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Smith				14. MOTHER'S MAIDEN NAME Annie Brooks Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Yes			
17. INFORMANT Mr. Harrington Smith, Williamsburg, Maryland.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Pace Jr.				M.D. DATE SIGNED 11/1/60			
EXAMINER'S NAME (Type) John Pace Jr.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/2/1960.			
22c. NAME OF CEMETERY OR CREMATORY Gethsemane Church Yard.				22d. LOCATION (City, town, or country) (State) Madison, Maryland.			
23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Maryland.				24a. REC'D BY REGISTRAR DATE NOV 9 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

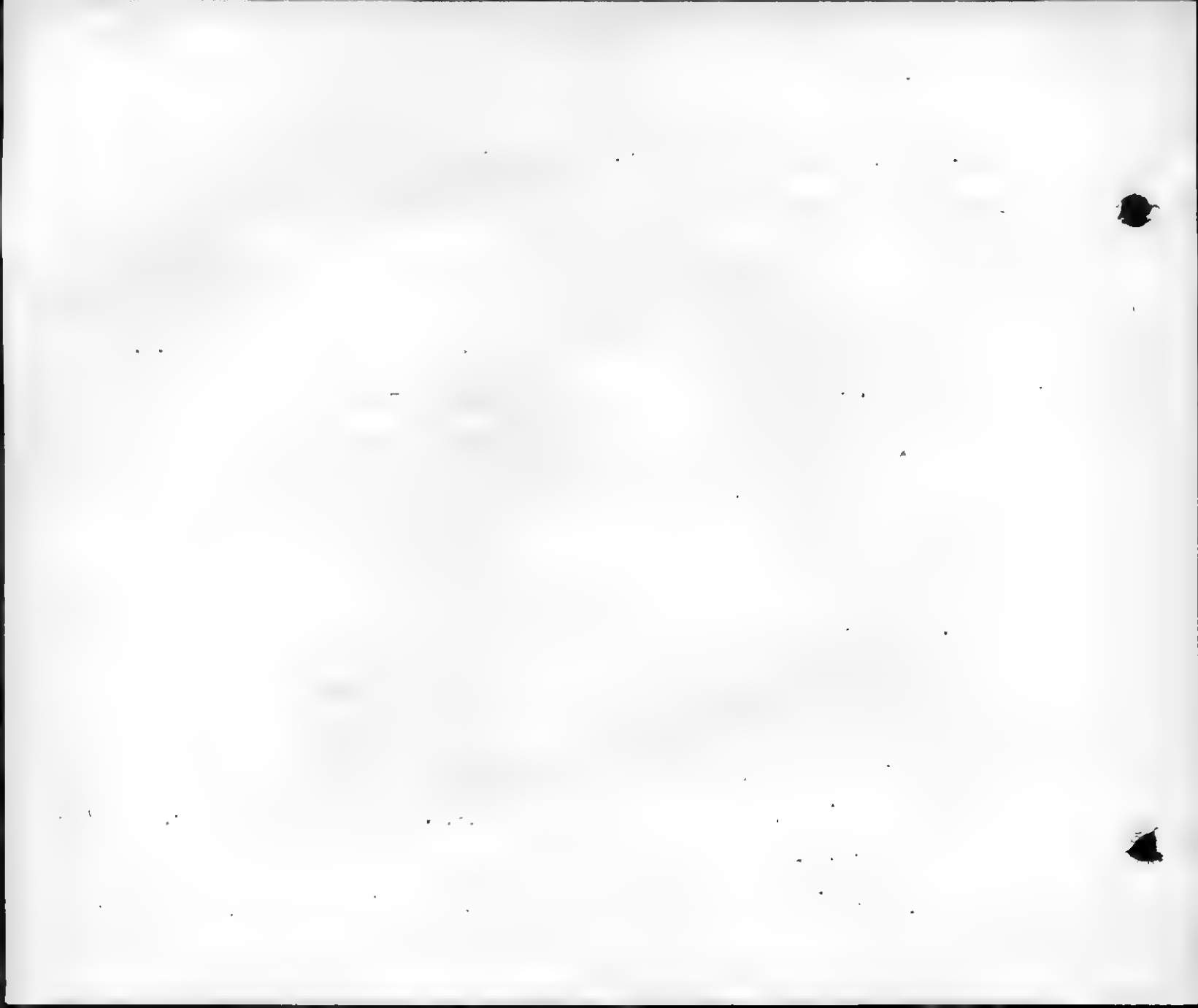


11368

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Maryland b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORNELIA Middle STERLING Last STERLING		4. DATE OF DEATH Month October 21 Day 19 Year 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/70
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 90 Days 90 Hours 90 Min 90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Sterling		14. MOTHER'S MAIDEN NAME Harriet - UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chr. Brain Syndrome due to senile brain disease, with psychosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/8 , 19 53 , to 10/21 , 19 60 , that I last saw the deceased alive on 10/21 , 19 60 , and that death occurred at 10:58 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED E.S.S. Hospital, Cambridge, Md. 10/21/60			
ACTUAL SIGNATURE Thomas J. Dredge M.D.		PHYSICIAN'S NAME (Type) Thomas J. Dredge	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Oct. 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Christy Cemetery		Crisfield Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Heinmann		24a. REC'D BY REGISTRAR DATE OCT 25 '60	
ADDRESS Crisfield		24b. REGISTRAR'S SIGNATURE Arthur J. Kraus	



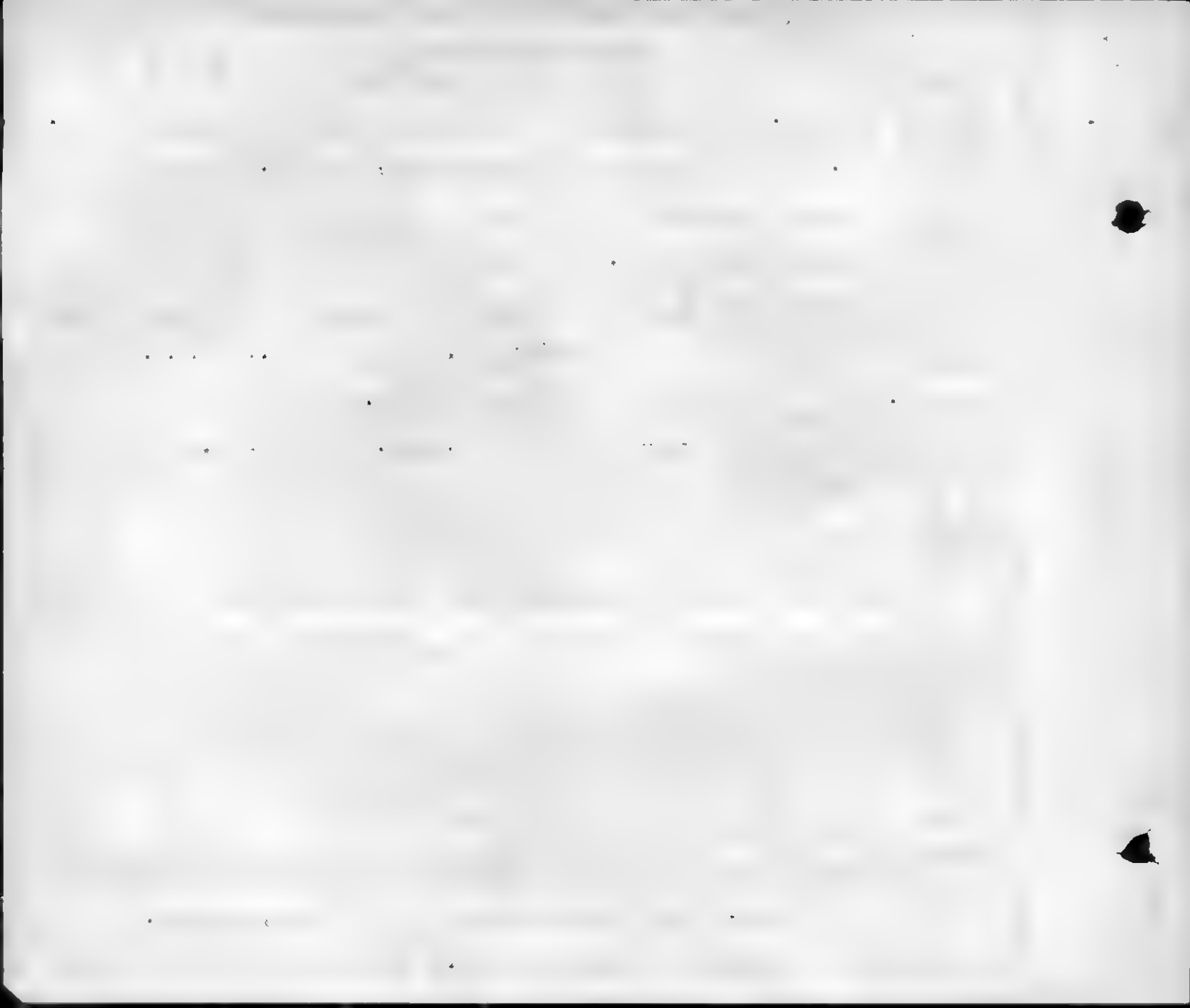
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11355 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

11346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toddville, Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland Hospital</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Winnie</u> Middle <u>M.</u> Last <u>Todd</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/4/1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>15</u> Days <u>19</u> Hours <u>60</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea Food Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tidewater Fishesies Comm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Toddville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rausme B. Todd</u>		14. MOTHER'S MAIDEN NAME <u>Roxie A. Todd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-34-3843</u>	
17. INFORMANT <u>Gillis S. Todd, Toddville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Branchopneumonia (Bilat)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Edronis lungs</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/10</u> , 19 <u>60</u> , to <u>10/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/15</u> , 19 <u>60</u> , and that death occurred at <u>2 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Hanks</u>		ADDRESS (Street, city or town, state) <u>104 Locust St</u>	
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>		DATE SIGNED <u>10/15/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/18/1960.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Toddville, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Hanks</u>			

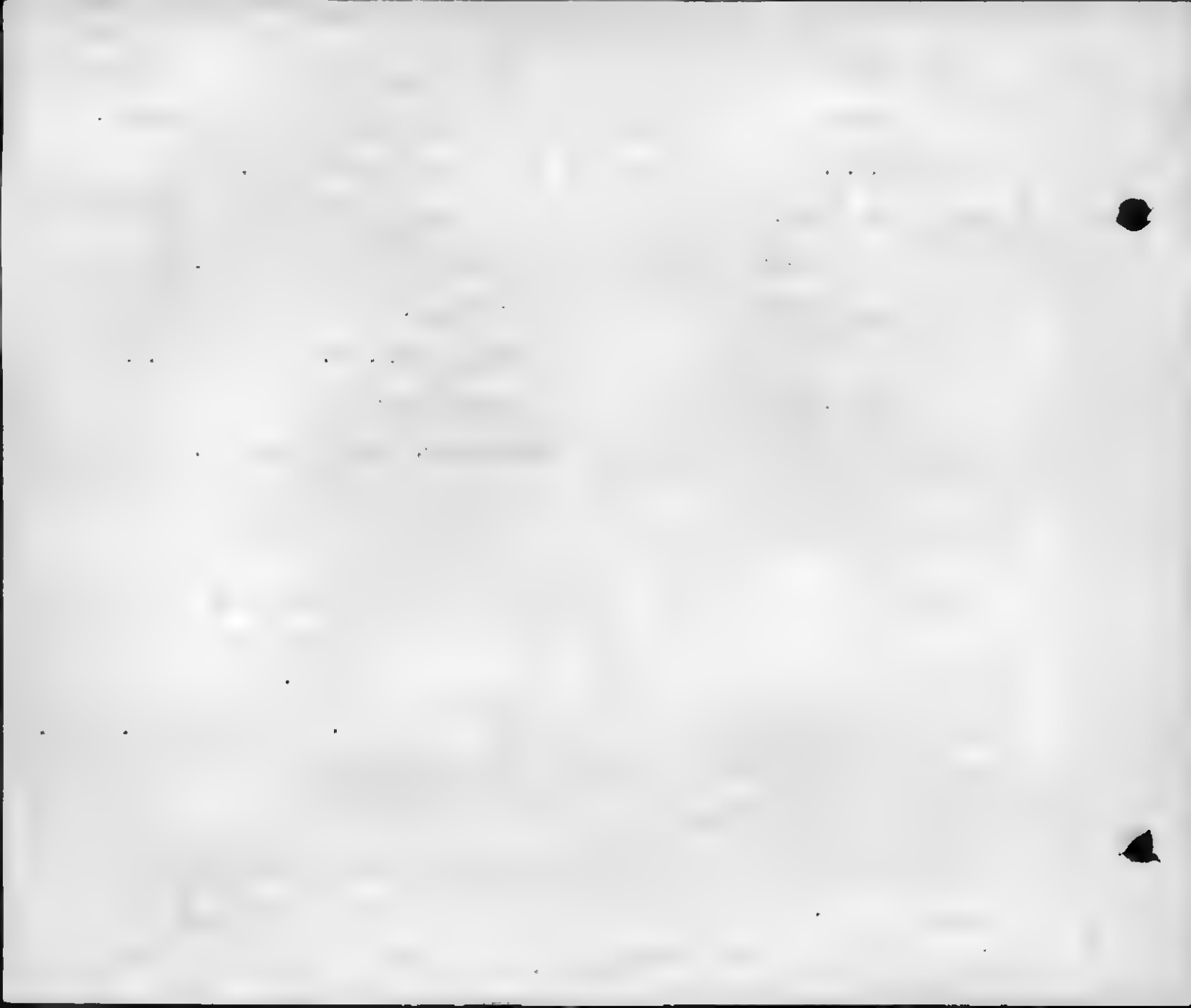


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13811											
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 1 c. LENGTH OF STAY IN 1b 8 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Found Dead on County Road						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fishing Creek, Md. d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Oliver Washington Tyler						4. DATE OF DEATH October 7, 1960					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						8. DATE OF BIRTH November 3, 1904					
9. AGE (in years last birthday) 55 yrs.						10. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Hoopersville, Md.						12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Samuel M. Tyler						14. MOTHER'S MAIDEN NAME Susan Hooper					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT Ackley Tyler, Fishing Creek, Md.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Focal hemorrhagic encephalopathy. DUE TO (b) Blow on head. DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Unknown how blow on head occurred.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 11/7/60											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> Unknown											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nr. Cambridge Dor. Md.											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/21/60											
DATE SIGNED											
ACTUAL SIGNATURE John Pace Jr. M.D.											
EXAMINER'S NAME (Type) John Pace Jr. M.D.											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF Oct. 9, 1960											
22c. NAME OF CEMETERY OR CREMATORY Southern Church Cem.											
22d. LOCATION (City, town, or country) (State) Hoopersville, Maryland											
23. FUNERAL DIRECTOR Herbert R. Howell											
ADDRESS Cambridge, Md.											
24a. REC'D BY REGISTRAR DEC 15 '60											
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											



1 11356 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

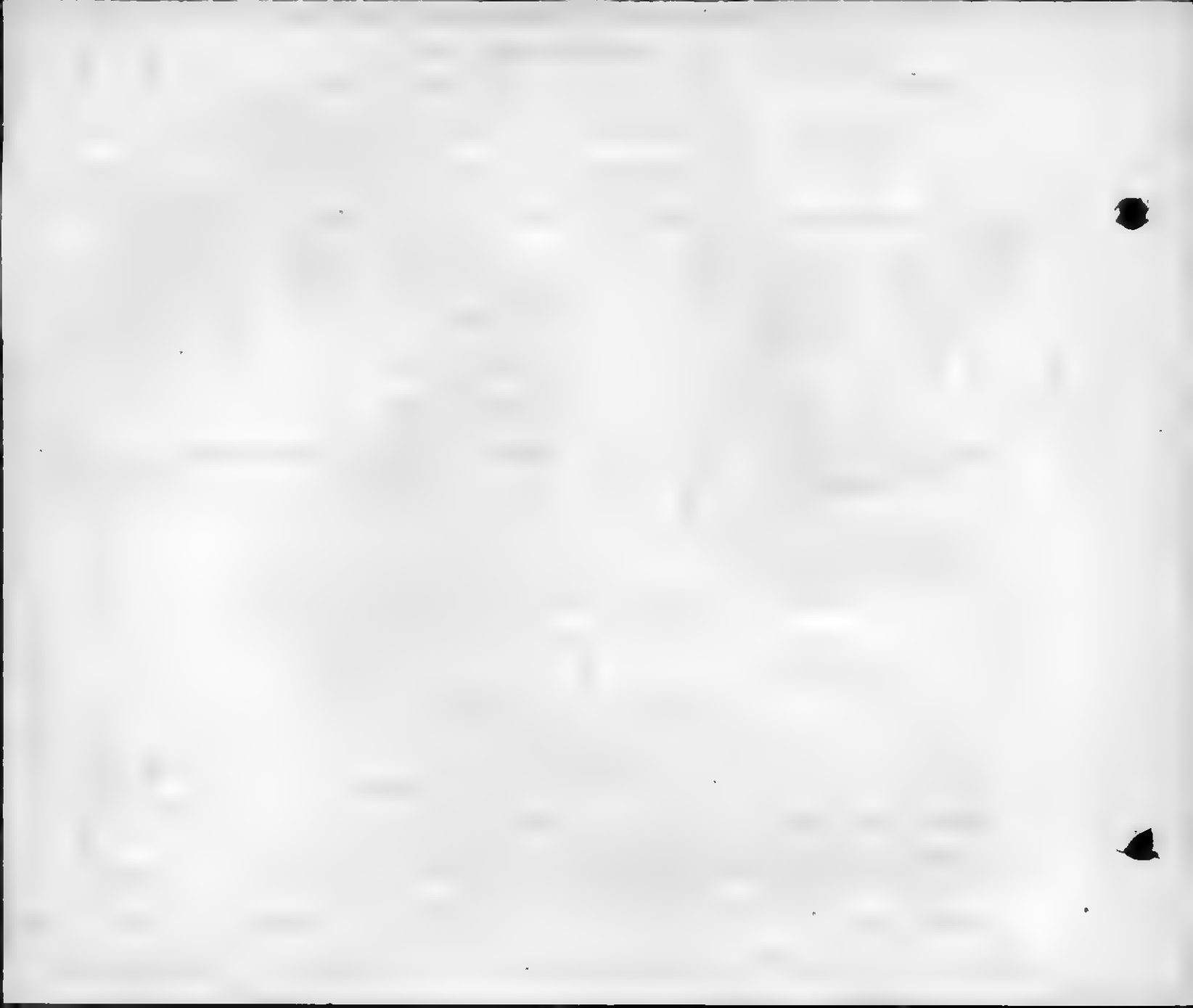
CERTIFICATE OF DEATH

Reg. Dist. No.

11347

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> 13	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		d. STREET ADDRESS <u>Hambrooks Blvd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Van Curen</u>		4. DATE OF DEATH Month Day Year <u>October 3 1960</u>	
5. SEX <u>M. le</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years lost birthday) yrs. <u>1</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>14</u> Hours <u>39</u> IF UNDER 24 HRS. Min. <u>39</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Morris Arthur Van Curen</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Charles Edward Barnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Jessie Van Curen - Hambrooks Blvd., Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>173.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>2-10-60</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-1-60</u> to <u>10-3-60</u> , that I last saw the deceased alive on <u>10-3-60</u> , and that death occurred at <u>3:15</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10-4-60</u>			
ACTUAL SIGNATURE <u>Dr. Wilbur N. Baumann</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. Wilbur N. Baumann - 3 Church Street - Cambridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 4, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Shover</u>		ADDRESS <u>Cambridge, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>OCT 6 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimm</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



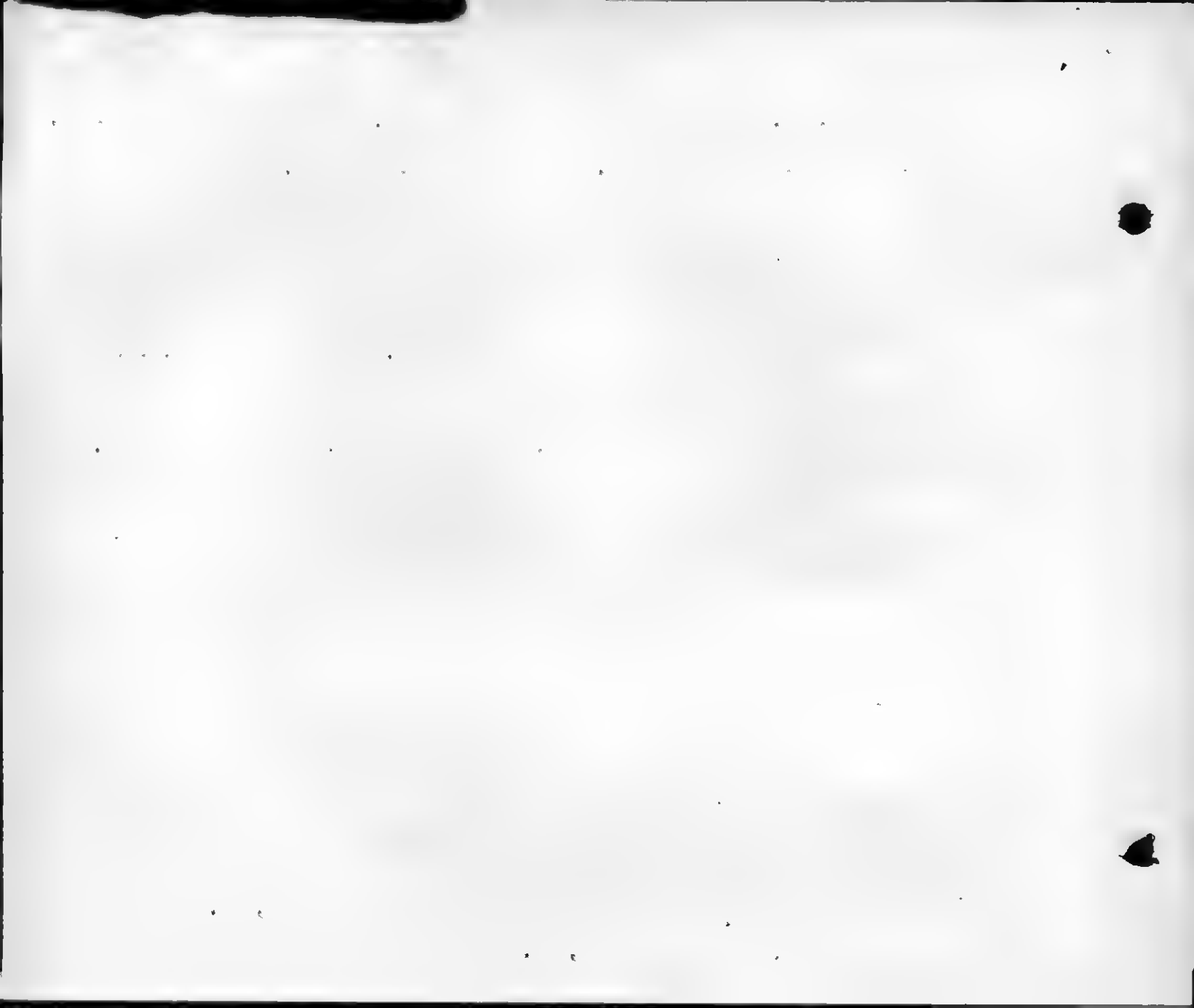
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
11370

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11348

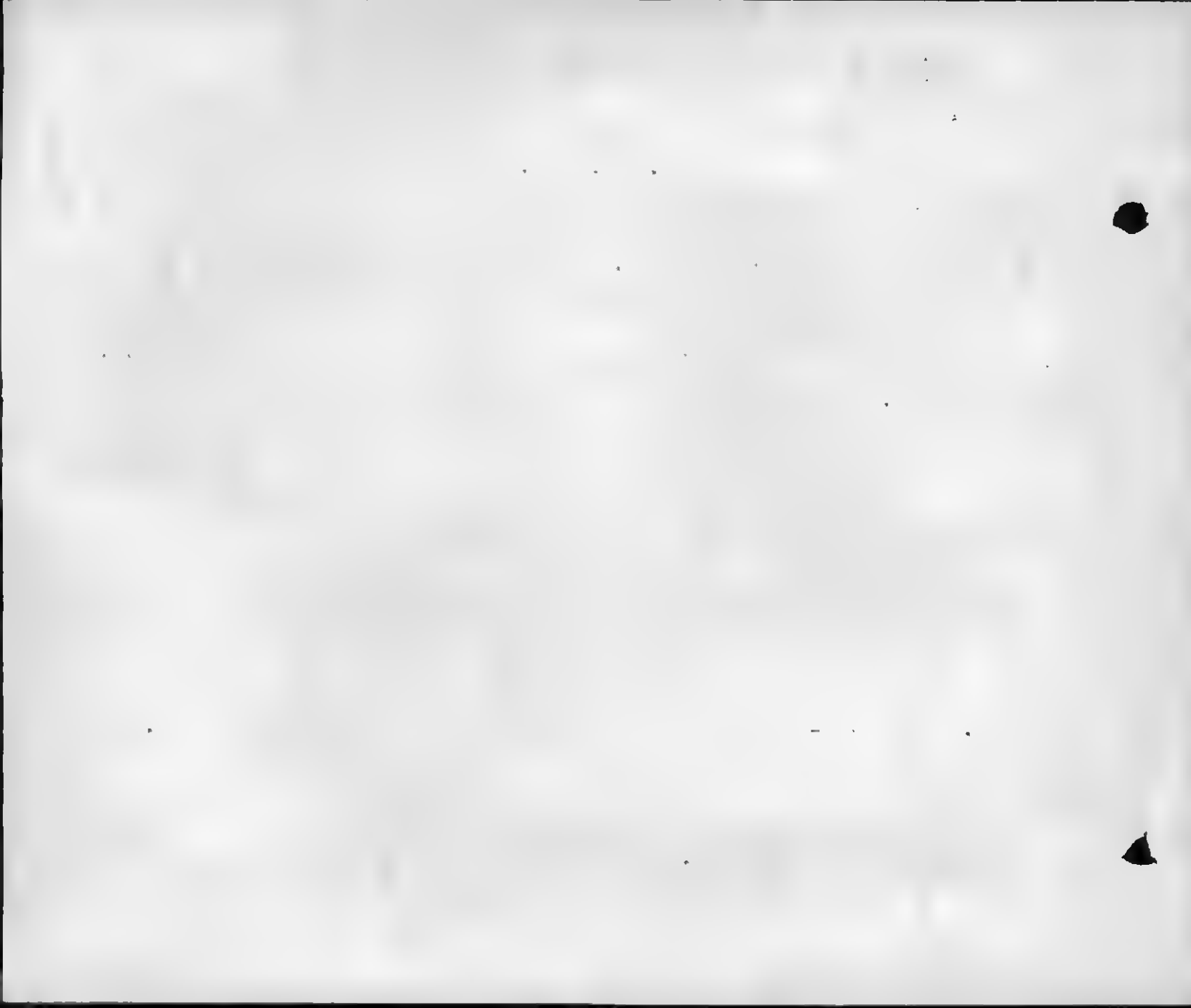
1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Dorchester, Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woolford, Maryland.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woolford, Maryland.</u>			
c. LENGTH OF STAY IN 1b <u>17 Years.</u>				d. STREET ADDRESS <u>None</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emily Louise McGowan Van Diver</u>				4. DATE OF DEATH Month Day Year <u>10 22 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/6/1900</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistical Reports</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Publishing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Clarence McGowan</u>				14. MOTHER'S MAIDEN NAME <u>Emma Germane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. Vernon Van Diver, Woolford, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Generalized carcinomatosis</u> DUE TO (c) <u>Adenocarcinoma, right breast</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 Months</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>(Radical amputation, right breast, Dec. 1958)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the undersigned) attended the deceased from <u>Dec. 16, 1958</u> , to <u>Oct. 22nd, 1960</u> , that (I) (the undersigned) last saw the deceased alive on <u>Oct. 22nd, 1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Eldridge H. Wolff</u>				22b. DATE <u>Oct. 24th, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M. D.</u>				22d. ADDRESS <u>15 Locust st., Cambridge, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10/25/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmont Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 4 '60</u>			
				25b. REGISTRAR'S SIGNATURE <u>Clara L. Thomas</u>			



VS. A15ME
5M 7/59

11340

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1yr. 2mos. 25das	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) East New Market	
3. NAME OF DECEASED (Type or print) Edna M. Varnes		4. DATE OF DEATH Month October Day 31 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-86 (?)
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Varnes		14. MOTHER'S MAIDEN NAME Sara Hooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Eastern Shore State Hospital Records		Address Eastern Shore State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 9047 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Fracture neck left femur DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell against bed rail 20c. TIME OF INJURY Month, Day, Year 9:30 a.m. 10-26-60 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital 20f. (City or town) (County) (State) Cambridge Dor. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		DATE SIGNED 10/31/60	
EXAMINER'S NAME (Type) John Mace Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY East New Market		22d. LOCATION (City, town, or country) (State) East New Market Md	
23. FUNERAL DIRECTOR H. H. Wallaughly & Son		24a. REC'D BY REGISTRAR NOV 3 '60	
ADDRESS H. H. Wallaughly & Son		24b. REGISTRAR'S SIGNATURE G. H. K.	



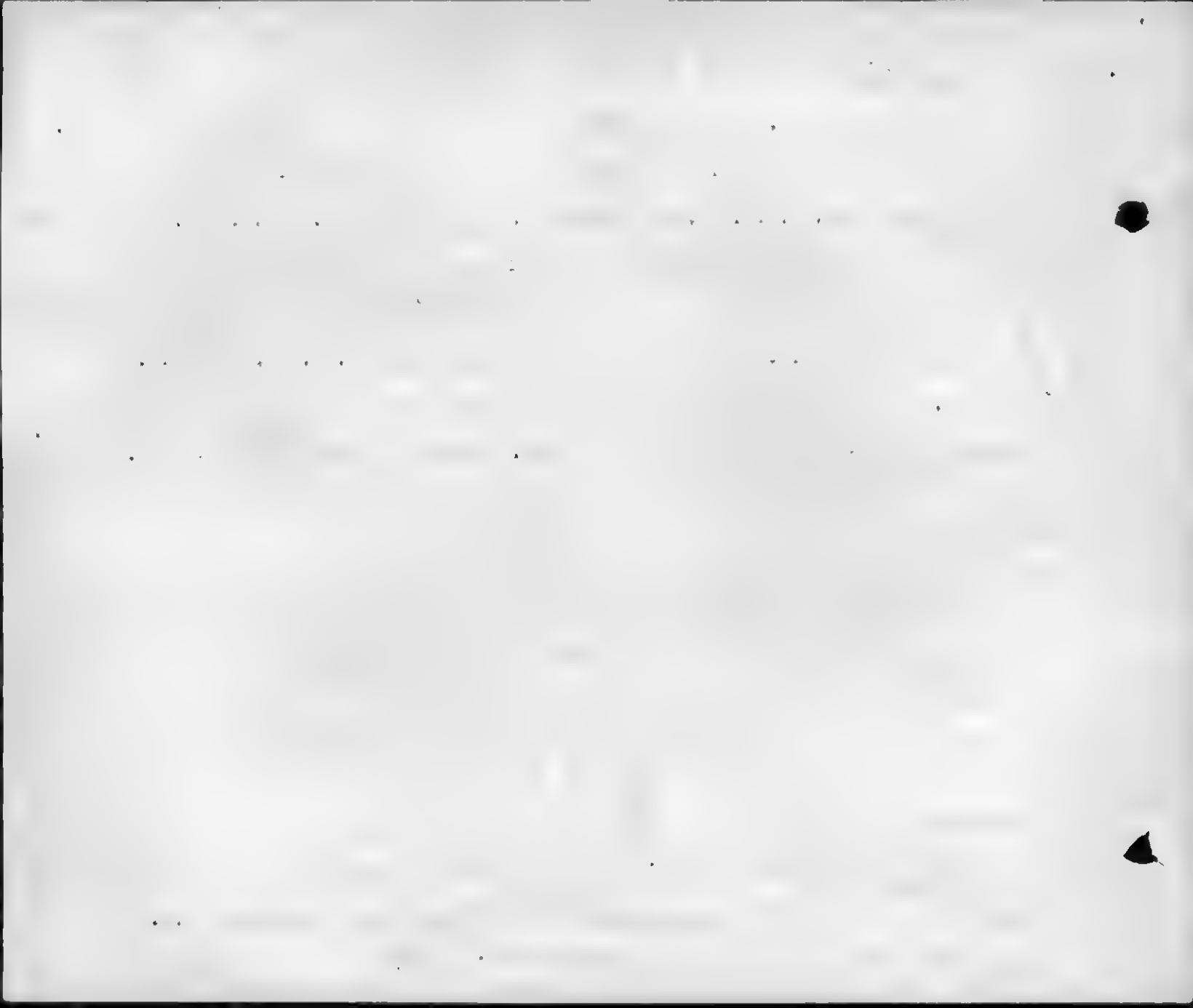
1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If an autopsy is necessary, the body shall be retained for your funeral director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11350											
1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u> c. LENGTH OF STAY IN 1b <u>10 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hambrooks Blvd., R.F.D.# 1, Cambridge, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u> d. STREET ADDRESS <u>Hambrooks Blvd., R.F.D.# 1,</u>							
3. NAME OF DECEASED (Type or print) <u>Charles Leroy Walker</u>				4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1960</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/19/1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chesapeake Ohio R.R. Railroad</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>Charles City Co. W. Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>G. Michael Walker</u>				14. MOTHER'S MAIDEN NAME <u>Alta Jones</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW-1</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Mrs. Charles Walker, Hambrooks, Blvd. Cambridge</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>420.1</u> DUE TO cause test.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
21. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
22f. (City or town) (County) (State)				23. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
24. ACTUAL SIGNATURE <u>John Mace Jr.</u>				25. EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				26. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
27. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				28. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				29. DATE SIGNED <u>10/26/60</u>			
30. ADDRESS (Street, city, town, or county)				31. 24b. REC'D BY REGISTRAR 24c. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>							
32. 24d. LOCATION (City, town, or county) (State)				33. 24e. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Washington, D.C.</u>							
34. 24f. LOCATION (City, town, or county) (State)				35. 24g. LOCATION (City, town, or county) (State)							
36. 24h. LOCATION (City, town, or county) (State)				37. 24i. LOCATION (City, town, or county) (State)							
38. 24j. LOCATION (City, town, or county) (State)				39. 24k. LOCATION (City, town, or county) (State)							
40. 24l. LOCATION (City, town, or county) (State)				41. 24m. LOCATION (City, town, or county) (State)							
42. 24n. LOCATION (City, town, or county) (State)				43. 24o. LOCATION (City, town, or county) (State)							
44. 24p. LOCATION (City, town, or county) (State)				45. 24q. LOCATION (City, town, or county) (State)							
46. 24r. LOCATION (City, town, or county) (State)				47. 24s. LOCATION (City, town, or county) (State)							
48. 24t. LOCATION (City, town, or county) (State)				49. 24u. LOCATION (City, town, or county) (State)							
50. 24v. LOCATION (City, town, or county) (State)				51. 24w. LOCATION (City, town, or county) (State)							
52. 24x. LOCATION (City, town, or county) (State)				53. 24y. LOCATION (City, town, or county) (State)							
54. 24z. LOCATION (City, town, or county) (State)				55. 24aa. LOCATION (City, town, or county) (State)							
56. 24ab. LOCATION (City, town, or county) (State)				57. 24ac. LOCATION (City, town, or county) (State)							
58. 24ad. LOCATION (City, town, or county) (State)				59. 24ae. LOCATION (City, town, or county) (State)							
60. 24af. LOCATION (City, town, or county) (State)				61. 24ag. LOCATION (City, town, or county) (State)							
62. 24ah. LOCATION (City, town, or county) (State)				63. 24ai. LOCATION (City, town, or county) (State)							
64. 24aj. LOCATION (City, town, or county) (State)				65. 24ak. LOCATION (City, town, or county) (State)							
66. 24al. LOCATION (City, town, or county) (State)				67. 24am. LOCATION (City, town, or county) (State)							
68. 24an. LOCATION (City, town, or county) (State)				69. 24ao. LOCATION (City, town, or county) (State)							
70. 24ap. LOCATION (City, town, or county) (State)				71. 24aq. LOCATION (City, town, or county) (State)							
72. 24ar. LOCATION (City, town, or county) (State)				73. 24as. LOCATION (City, town, or county) (State)							
74. 24at. LOCATION (City, town, or county) (State)				75. 24au. LOCATION (City, town, or county) (State)							
76. 24av. LOCATION (City, town, or county) (State)				77. 24aw. LOCATION (City, town, or county) (State)							
78. 24ax. LOCATION (City, town, or county) (State)				79. 24ay. LOCATION (City, town, or county) (State)							
80. 24az. LOCATION (City, town, or county) (State)				81. 24ba. LOCATION (City, town, or county) (State)							
82. 24bb. LOCATION (City, town, or county) (State)				83. 24bc. LOCATION (City, town, or county) (State)							
84. 24bd. LOCATION (City, town, or county) (State)				85. 24be. LOCATION (City, town, or county) (State)							
86. 24bf. LOCATION (City, town, or county) (State)				87. 24bg. LOCATION (City, town, or county) (State)							
88. 24bh. LOCATION (City, town, or county) (State)				89. 24bi. LOCATION (City, town, or county) (State)							
90. 24bj. LOCATION (City, town, or county) (State)				91. 24bk. LOCATION (City, town, or county) (State)							
92. 24bl. LOCATION (City, town, or county) (State)				93. 24bm. LOCATION (City, town, or county) (State)							
94. 24bn. LOCATION (City, town, or county) (State)				95. 24bo. LOCATION (City, town, or county) (State)							
96. 24bp. LOCATION (City, town, or county) (State)				97. 24bq. LOCATION (City, town, or county) (State)							
98. 24br. LOCATION (City, town, or county) (State)				99. 24bs. LOCATION (City, town, or county) (State)							
100. 24bt. LOCATION (City, town, or county) (State)				101. 24bu. LOCATION (City, town, or county) (State)							
102. 24bv. LOCATION (City, town, or county) (State)				103. 24bw. LOCATION (City, town, or county) (State)							
104. 24bx. LOCATION (City, town, or county) (State)				105. 24by. LOCATION (City, town, or county) (State)							
106. 24bz. LOCATION (City, town, or county) (State)				107. 24ca. LOCATION (City, town, or county) (State)							
108. 24cb. LOCATION (City, town, or county) (State)				109. 24cc. LOCATION (City, town, or county) (State)							
110. 24cd. LOCATION (City, town, or county) (State)				111. 24ce. LOCATION (City, town, or county) (State)							
112. 24cd. LOCATION (City, town, or county) (State)				113. 24cf. LOCATION (City, town, or county) (State)							
114. 24ce. LOCATION (City, town, or county) (State)				115. 24cg. LOCATION (City, town, or county) (State)							
116. 24cd. LOCATION (City, town, or county) (State)				117. 24ch. LOCATION (City, town, or county) (State)							
118. 24ce. LOCATION (City, town, or county) (State)				119. 24ci. LOCATION (City, town, or county) (State)							
120. 24cd. LOCATION (City, town, or county) (State)				121. 24cj. LOCATION (City, town, or county) (State)							
122. 24ce. LOCATION (City, town, or county) (State)				123. 24ck. LOCATION (City, town, or county) (State)							
124. 24cd. LOCATION (City, town, or county) (State)				125. 24cl. LOCATION (City, town, or county) (State)							
126. 24ce. LOCATION (City, town, or county) (State)				127. 24cm. LOCATION (City, town, or county) (State)							
128. 24cd. LOCATION (City, town, or county) (State)				129. 24cn. LOCATION (City, town, or county) (State)							
130. 24ce. LOCATION (City, town, or county) (State)				131. 24co. LOCATION (City, town, or county) (State)							
132. 24cd. LOCATION (City, town, or county) (State)				133. 24cp. LOCATION (City, town, or county) (State)							
134. 24ce. LOCATION (City, town, or county) (State)				135. 24cq. LOCATION (City, town, or county) (State)							
136. 24cd. LOCATION (City, town, or county) (State)				137. 24cr. LOCATION (City, town, or county) (State)							
138. 24ce. LOCATION (City, town, or county) (State)				139. 24cs. LOCATION (City, town, or county) (State)							
140. 24cd. LOCATION (City, town, or county) (State)				141. 24ct. LOCATION (City, town, or county) (State)							
142. 24ce. LOCATION (City, town, or county) (State)				143. 24cu. LOCATION (City, town, or county) (State)							
144. 24cd. LOCATION (City, town, or county) (State)				145. 24cv. LOCATION (City, town, or county) (State)							
146. 24ce. LOCATION (City, town, or county) (State)				147. 24cw. LOCATION (City, town, or county) (State)							
148. 24cd. LOCATION (City, town, or county) (State)				149. 24cx. LOCATION (City, town, or county) (State)							
150. 24ce. LOCATION (City, town, or county) (State)				151. 24cy. LOCATION (City, town, or county) (State)							
152. 24cd. LOCATION (City, town, or county) (State)				153. 24cz. LOCATION (City, town, or county) (State)							
154. 24ce. LOCATION (City, town, or county) (State)				155. 24da. LOCATION (City, town, or county) (State)							
156. 24cd. LOCATION (City, town, or county) (State)				157. 24db. LOCATION (City, town, or county) (State)							
158. 24ce. LOCATION (City, town, or county) (State)				159. 24dc. LOCATION (City, town, or county) (State)							
160. 24cd. LOCATION (City, town, or county) (State)				161. 24dd. LOCATION (City, town, or county) (State)							
162. 24ce. LOCATION (City, town, or county) (State)				163. 24de. LOCATION (City, town, or county) (State)							
164. 24cd. LOCATION (City, town, or county) (State)				165. 24df. LOCATION (City, town, or county) (State)							
166. 24ce. LOCATION (City, town, or county) (State)				167. 24dg. LOCATION (City, town, or county) (State)							
168. 24cd. LOCATION (City, town, or county) (State)				169. 24dh. LOCATION (City, town, or county) (State)							
170. 24ce. LOCATION (City, town, or county) (State)				171. 24di. LOCATION (City, town, or county) (State)							
172. 24cd. LOCATION (City, town, or county) (State)				173. 24dj. LOCATION (City, town, or county) (State)							
174. 24ce. LOCATION (City, town, or county) (State)				175. 24dk. LOCATION (City, town, or county) (State)							
176. 24cd. LOCATION (City, town, or county) (State)				177. 24dl. LOCATION (City, town, or county) (State)							
178. 24ce. LOCATION (City, town, or county) (State)				179. 24dm. LOCATION (City, town, or county) (State)							
180. 24cd. LOCATION (City, town, or county) (State)				181. 24dn. LOCATION (City, town, or county) (State)							
182. 24ce. LOCATION (City, town, or county) (State)				183. 24do. LOCATION (City, town, or county) (State)							
184. 24cd. LOCATION (City, town, or county) (State)				185. 24dp. LOCATION (City, town, or county) (State)							
186. 24ce. LOCATION (City, town, or county) (State)				187. 24dq. LOCATION (City, town, or county) (State)							
188. 24cd. LOCATION (City, town, or county) (State)				189. 24dr. LOCATION (City, town, or county) (State)							
190. 24ce. LOCATION (City, town, or county) (State)				191. 24ds. LOCATION (City, town, or county) (State)							
192. 24cd. LOCATION (City, town, or county) (State)				193. 24dt. LOCATION (City, town, or county) (State)							
194. 24ce. LOCATION (City, town, or county) (State)				195. 24du. LOCATION (City, town, or county) (State)							
196. 24cd. LOCATION (City, town, or county) (State)				197. 24dv. LOCATION (City, town, or county) (State)							
198. 24ce. LOCATION (City, town, or county) (State)				199. 24dw. LOCATION (City, town, or county) (State)							
200. 24cd. LOCATION (City, town, or county) (State)				201. 24dx. LOCATION (City, town, or county) (State)							
202. 24ce. LOCATION (City, town, or county) (State)				203. 24dy. LOCATION (City, town, or county) (State)							
204. 24cd. LOCATION (City, town, or county) (State)				205. 24dz. LOCATION (City, town, or county) (State)							
206. 24ce. LOCATION (City, town, or county) (State)				207. 24ea. LOCATION (City, town, or county) (State)							
208. 24cd. LOCATION (City, town, or county) (State)				209. 24eb. LOCATION (City, town, or county) (State)							
210. 24ce. LOCATION (City, town, or county) (State)				211. 24ec. LOCATION (City, town, or county) (State)							
212. 24cd. LOCATION (City, town, or county) (State)				213. 24ed. LOCATION (City, town, or county) (State)							
214. 24ce. LOCATION (City, town, or county) (State)				215. 24ee. LOCATION (City, town, or county) (State)							
216. 24cd. LOCATION (City, town, or county) (State)				217. 24ef. LOCATION (City, town, or county) (State)							
218. 24ce. LOCATION (City, town, or county) (State)				219. 24eg. LOCATION (City, town, or county) (State)							
220. 24cd. LOCATION (City, town, or county) (State)				221. 24eh. LOCATION (City, town, or county) (State)							
222. 24ce. LOCATION (City, town, or county) (State)				223. 24ei. LOCATION (City, town, or county) (State)							
224. 24cd. LOCATION (City, town, or county) (State)				225. 24ej. LOCATION (City, town, or county) (State)							
226. 24ce. LOCATION (City, town, or county) (State)				227. 24ek. LOCATION (City, town, or county) (State)							
228. 24cd. LOCATION (City, town, or county) (State)				229. 24el. LOCATION (City, town, or county) (State)							
230. 24ce. LOCATION (City, town, or county) (State)				231. 24em. LOCATION (City, town, or county) (State)							
232. 24cd. LOCATION (City, town, or county) (State)				233. 24en. LOCATION (City, town, or county) (State)							
234. 24ce. LOCATION (City, town, or county) (State)				235. 24eo. LOCATION (City, town, or county) (State)							
236. 24cd. LOCATION (City, town, or county) (State)				237. 24ep. LOCATION (City, town, or county) (State)							
238. 24ce. LOCATION (City, town, or county) (State)				239. 24eq. LOCATION (City, town, or county) (State)							
240. 24cd. LOCATION (City, town, or county) (State)				241. 24er. LOCATION (City, town, or county) (State)							
242. 24ce. LOCATION (City, town, or county) (State)				243. 24es. LOCATION (City, town, or county) (State)							
244. 24cd. LOCATION (City, town, or county) (State)				245. 24et. LOCATION (City, town, or county) (State)							
246. 24ce. LOCATION (City, town, or county) (State)				247. 24eu. LOCATION (City, town, or county) (State)							
248. 24cd. LOCATION (City, town, or county) (State)				249. 24ev. LOCATION (City, town, or county) (State)							
250. 24ce. LOCATION (City, town, or county) (State)				251. 24ew. LOCATION (City, town, or county) (State)							
252. 24cd. LOCATION (City, town, or county) (State)				253. 24ex. LOCATION (City, town, or county) (State)							
254. 24ce. LOCATION (City, town, or county) (State)				255. 24ey. LOCATION (City, town, or county) (State)							
256. 24cd. LOCATION (City, town, or county) (State)				257. 24ez. LOCATION (City, town, or county) (State)							
258. 24ce. LOCATION (City, town, or county) (State)				259. 24fa. LOCATION (City, town, or county) (State)							
260. 24cd. LOCATION (City, town, or county) (State)				261. 24fb. LOCATION (City, town, or county) (State)							
262. 24ce. LOCATION (City, town, or county) (State)				263. 24fc. LOCATION (City, town, or county) (State)							
264. 24cd. LOCATION (City, town, or county) (State)				265. 24fd. LOCATION (City, town, or county) (State)							
266. 24ce. LOCATION (City, town, or county) (State)				267. 24fe. LOCATION (City, town, or county) (State)							
268. 24cd. LOCATION (City, town, or county) (State)				269. 24ff. LOCATION (City, town, or county) (State)							
270. 24ce. LOCATION (City, town, or county) (State)				271. 24fg. LOCATION (City, town, or county) (State)							
272. 24cd. LOCATION (City, town, or county) (State)				273. 24fh. LOCATION (City, town, or county) (State)							
274. 24ce. LOCATION (City, town, or county) (State)				275. 24fi. LOCATION (City, town, or county) (State)							
276. 24cd. LOCATION (City, town, or county) (State)				277. 24fj. LOCATION (City, town, or county) (State)							
278. 24ce. LOCATION (City, town, or county) (State)				279. 24fk. LOCATION (City, town, or county) (State)							
280. 24cd. LOCATION (City, town, or county) (State)				281. 24fl. LOCATION (City, town, or county) (State)							
282. 24ce. LOCATION (City, town, or county) (State)				283. 24fm. LOCATION (City, town, or county) (State)							
284. 24cd. LOCATION (City, town, or county) (State)				285. 24fn. LOCATION (City, town, or county) (State)							
286. 24ce. LOCATION (City, town, or county) (State)				287. 24fo. LOCATION (City, town, or county) (State)							
288. 24cd. LOCATION (City, town, or county) (State)				289. 24fp. LOCATION (City, town, or county) (State)							
290. 24ce. LOCATION (City, town, or county) (State)				291. 24fq. LOCATION (City, town, or county) (State)							
292. 24cd. LOCATION (City, town, or county) (State)				293. 24fr. LOCATION (City, town, or county) (State)							
294. 24ce. LOCATION (City, town, or county) (State)				295. 24fs. LOCATION (City, town, or county) (State)							
296. 24cd. LOCATION (City, town, or county) (State)				297. 24ft. LOCATION (City, town, or county) (State)							
298. 24ce. LOCATION (City, town, or county) (State)				299. 24fu. LOCATION (City, town, or county) (State)							
300. 24cd. LOCATION (City, town, or county) (State)				301. 24fv. LOCATION (City, town, or county) (State)							
302. 24ce. LOCATION (City, town, or county) (State)				303. 24fw. LOCATION (City, town, or county) (State)							
304. 24cd. LOCATION (City, town, or county) (State)				305. 24fx. LOCATION (City, town, or county) (State)							
306. 24ce. LOCATION (City, town, or county) (State)				307. 24fy. LOCATION (City, town, or county) (State)							
308. 24cd. LOCATION (City, town, or county) (State)				309. 24fz. LOCATION (City, town, or county) (State)							
310. 24ce. LOCATION (City, town, or county) (State)				311. 24ga. LOCATION (City, town, or county) (State)							
312. 24cd. LOCATION (City, town, or county) (State)				313. 24gb. LOCATION (City, town, or county) (State)							
314. 24ce. LOCATION (City, town, or county) (State)				315. 24gc. LOCATION (City, town, or county) (State)							
316. 24cd. LOCATION (City, town, or county) (State)				317. 24gd. LOCATION (City, town, or county) (State)							
318. 24ce. LOCATION (City, town, or county) (State)				319. 24ge. LOCATION (City, town, or county) (State)							
320. 24cd. LOCATION (City, town, or county) (State)				321. 24gf. LOCATION (City, town, or county) (State)							
322. 24ce. LOCATION (City, town, or county) (State)				323. 24gg. LOCATION (City, town, or county) (State)							
324. 24cd. LOCATION (City, town, or county) (State)				325. 24gh. LOCATION (City, town, or county) (State)							
326. 24ce. LOCATION (City, town, or county) (State)				327. 24gi. LOCATION (City, town, or county) (State)							
328. 24cd. LOCATION (City, town, or county) (State)				329. 24gj. LOCATION (City, town, or county) (State)							
330. 24ce. LOCATION (City, town, or county) (State)				331. 24gk. LOCATION (City, town, or county) (State)							
332. 24cd. LOCATION (City, town, or county) (State)				333. 24gl. LOCATION (City, town, or county) (State)							
334. 24ce. LOCATION (City, town, or county) (State)				335. 24gm. LOCATION (City, town, or county) (State)							
336. 24cd. LOCATION (City, town, or county) (State)				337. 24gn. LOCATION (City, town, or county) (State)							
338. 24ce. LOCATION (City, town, or county) (State)				339. 24go. LOCATION (City, town, or county) (State)							
340. 24cd. LOCATION (City, town, or county) (State)				341. 24gp. LOCATION (City, town, or county) (State)							
342. 24ce. LOCATION (City, town, or county) (State)				343. 24gq. LOCATION (City, town, or county) (State)							
344. 24cd. LOCATION (City, town, or county) (State)				345. 24gr. LOCATION (City, town, or county) (State)							
346. 24ce. LOCATION (City, town, or county) (State)				347. 24gs. LOCATION (City, town, or county) (State)							
348. 24cd. LOCATION (City, town, or county) (State)				349. 24gt. LOCATION (City, town, or county) (State)							
350. 24ce. LOCATION (City, town, or county) (State)				351. 24gu. LOCATION (City, town, or county) (State)							
352. 24cd. LOCATION (City, town, or county) (State)				353. 24gv. LOCATION (City, town, or county) (State)							
354. 24ce. LOCATION (City, town, or county) (State)				355. 24gw. LOCATION (City, town, or county) (State)							
356. 24cd. LOCATION (City, town, or county) (State)				357. 24gx. LOCATION (City, town, or county) (State)							
358. 24ce. LOCATION (City, town, or county) (State)				359. 24gy. LOCATION (City, town, or county) (State)							
360. 24cd. LOCATION (City, town, or county) (State)				361. 24gz. LOCATION (City, town, or county) (State)							
362. 24ce. LOCATION (City, town, or county) (State)				363. 24ha. LOCATION (City, town, or county) (State)							
364. 24cd. LOCATION (City, town, or county) (State)				365. 24hb. LOCATION (City, town, or county) (State)							
366. 24ce. LOCATION (City, town, or county) (State)				367. 24hc. LOCATION (City, town, or county) (State)							
368. 24cd. LOCATION (City, town, or county) (State)				369. 24hd. LOCATION (City, town, or county) (State)							
370. 24ce. LOCATION (City, town, or county) (State)				371. 24he. LOCATION (City, town, or county) (State)							
372. 24cd. LOCATION (City, town, or county) (State)				373. 24hf. LOCATION (City, town, or county) (State)							
374. 24ce. LOCATION (City, town, or county) (State)				375. 24hg. LOCATION (City, town, or county) (State)							
376. 24cd. LOCATION (City, town, or county) (State)				377. 24hh. LOCATION (City, town, or county) (State)							
378. 24ce. LOCATION (City, town, or county) (State)				379. 24hi. LOCATION (City, town, or county) (State)							
380. 24cd. LOCATION (City, town, or county) (State)				381. 24hj. LOCATION (City, town, or county) (State)							
382. 24ce. LOCATION (City, town, or county) (State)				383. 24hk. LOCATION (City, town, or county) (State)							



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 18 Film 276 12-6-60 ans</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>11357 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>11351</div>											
1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY in 1b 8 Wks.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Hosp.				d. STREET ADDRESS 633 Dover				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hayward T. WEBB				4. DATE OF DEATH October 20 19 60							
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-96		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor				10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Asbury Webb				14. MOTHER'S MAIDEN NAME Rosa Friend							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. —		17. INFORMANT Miss Lois Webb, Easton, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Fractures of Pelvis										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Easton		(County) Md.		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED October 20, 1960											
ACTUAL SIGNATURE Wm. Updegraff		M.D.									
EXAMINER'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/60		22c. NAME OF CEMETERY OR CREMATORY Richards Cem.		22d. LOCATION (City, town, or country) Easton		(State) Md.			
23. FUNERAL DIRECTOR James D. Robie, Easton, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 24 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Evans			

MEDICAL CERTIFICATION

100-2111
MAY 1961

(M)

(17)

11111

Director

Assistant

3102

100-2111

3-8-72

Wobb

—

[Handwritten signature]

2

[Faint handwritten text at the bottom of the page]

1
FOR STATE
HEALTH DEPT.

TO DEFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

016

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland		b. COUNTY Caroline ✓		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Denton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital						d. STREET ADDRESS 05X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Edgar		Middle S.		Last Willis		4. DATE OF DEATH Month October		Day 9 Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1878		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick mason, retired		10b. KIND OF BUSINESS OR INDUSTRY Brick laying		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Harry Willis				14. MOTHER'S MAIDEN NAME unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. -		17. INFORMANT Records E.S.S. hospital		Address Cambridge, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion											
DUE TO Arteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) ?											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 10/9/60			
EXAMINER'S NAME (Type) John Mace Jr.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1960		22c. NAME OF CEMETERY OR CREMATORY Denton		22d. LOCATION (City, town, or country) Denton, Md		(County)		(State)	
23. FUNERAL DIRECTOR J. Virgil Moore						24a. REC'D BY REGISTRAR OCT 11 1960		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Moore</i>			

1152

1152

1152



[Faint, illegible handwritten text, possibly a signature or date]